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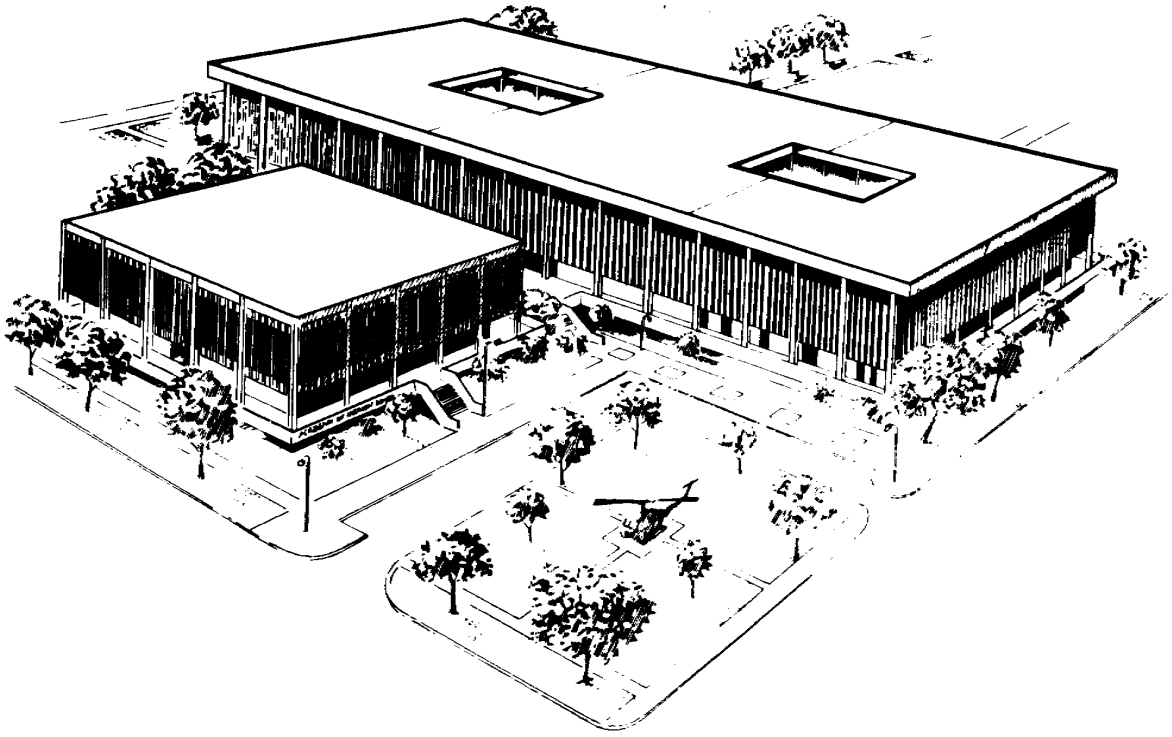
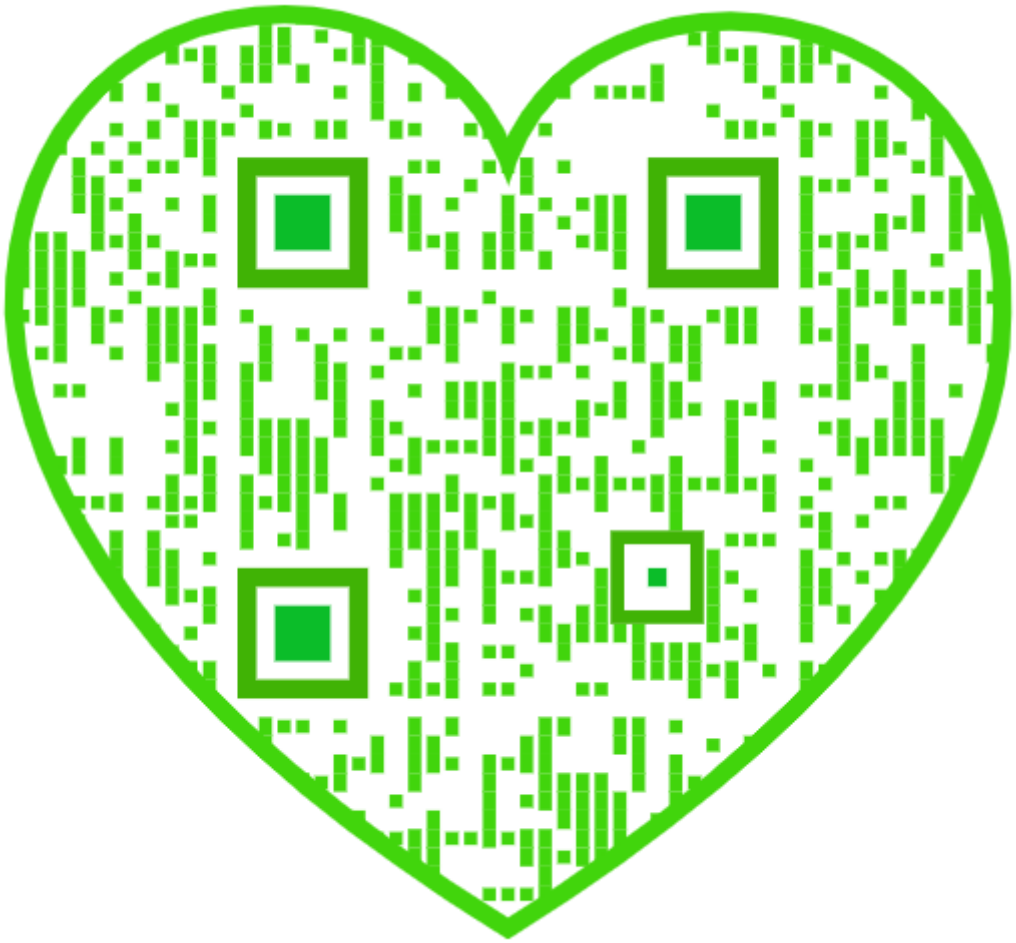


MENTAL HEALTH

SUBCOURSE MD0586 EDITION 100



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This subcourse is approved for resident and correspondence course instruction. It reflects the current thought of the Academy of Health Sciences and conforms to printed Department of the Army doctrine as closely as currently possible. Development and progress render such doctrine continuously subject to change.

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CLARIFICATION OF TERMINOLOGY

When used in this publication, words such as "he," "him," "his," and "men" 'are intended to include both the masculine and feminine genders, unless specifically stated otherwise or when obvious in context.

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CORRESPONDENCE COURSE OF
THE U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

SUBCOURSE MD0586

MENTAL HEALTH

INTRODUCTION

Today, people live in a fast-paced, fast-changing world. Daily, we are assailed by a series of crises ranging from international relations relating to the nuclear arms race and the threat of war to domestic issues such as employment opportunities, crime in the streets, environmental pollution, and the spiraling upward cost of living. Additionally, we must deal with more personal situations such as working while managing a household, giving care to children, getting the laundry done, shopping for food, etc. The list of situation with which we all deal on a daily basis is endless and mind-boggling. Soldiers have not only these daily stresses with which to deal, but also the unique stresses of their profession and the possibility of the major stress of combat.

Usually, we all cope with our situations successfully. Sometimes, however, we feel overwhelmed and we become mentally ill. Perhaps a physical problem--an accident or a chemical imbalance in the body--causes mental illness. Many people have brief periods of mental illness and then seem to recover completely. Others suffer from mental disorders for most of their lives. Regardless of the cause or the duration of the mental illness, it is important for you to be able to recognize and treat or refer for treatment any individual with mental health difficulties.

Subcourse Components:

The subcourse instructional material consists of seven lessons as follows:

Lesson 1, Normal/Abnormal Behavior.
Lesson 2, Burnout, Depression, and Suicide.
Lesson 3, Hostility and Violent Behavior.
Lesson 4, Substance Abuse.
Lesson 5, Combat Stress Reactions.
Lesson 6, Death and Dying.
Lesson 7, Sexual Assault.

Here are some suggestions that may be helpful to you in completing this subcourse:

--Read and study each lesson carefully.

--Complete the subcourse lesson by lesson. After completing each lesson, work the exercises at the end of the lesson, marking your answers in this booklet.

--After completing each set of lesson exercises, compare your answers with those on the solution sheet that follows the exercises. If you have answered an exercise incorrectly, check the reference cited after the answer on the solution sheet to determine why your response was not the correct one.

Credit Awarded:

Upon successful completion of the examination for this subcourse, you will be awarded 11 credit hours.

To receive credit hours, you must be officially enrolled and complete an examination furnished by the Nonresident Instruction Branch at Fort Sam Houston, Texas.

You can enroll by going to the web site http://atrrs.army.mil and enrolling under "Self Development" (School Code 555).

A listing of correspondence courses and subcourses available through the Nonresident Instruction Section is found in Chapter 4 of DA Pamphlet 350-59, Army Correspondence Course Program Catalog. The DA PAM is available at the following website: http://www.usapa.army.mil/pdffiles/p350-59.pdf.

LESSON ASSIGNMENT

LESSON 1	Normal/Abnormal Behavior.
LESSON ASSIGNMENT	Paragraphs 1-1 through 1-7.
LESSON OBJECTIVES	After completing this lesson, you should be able to:
	1-1. Define normal behavior.
	1-2. Identify the characteristics of normal behavior.
	1-3. Identify normal defense mechanisms.
	1-4. Define abnormal behavior.
	1-5. Identify the characteristics of abnormal behavior.
	1-6. Identify therapeutic interventions to treat abnormal behavior.
SUGGESTION	After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 1

NORMAL/ABNORMAL BEHAVIOR

1-1. INTRODUCTION

Intense physiological processes are continually taking place in the human body. Any disturbance or change from the delicate homeostatic balances in the body will result in severe consequences for the individual. Correct diagnosis and correct treatment are both necessary to remedy the situation. Just as a physical problem must be corrected, so a psychological problem also must be corrected. It is important to understand and distinguish between physiologically normal processes and those processes which are abnormal. Of just as great importance is the necessity to distinguish between psychologically normal processes and those that are abnormal.

1-2. NORMAL BEHAVIOR

a. **Definition.** The word behavior can be defined as the manner in which an individual acts or functions. The term normal behavior is a little more difficult to define. The society in which a person lives defines normal behavior for that individual. Additionally, behavior considered normal in one society may be considered totally abnormal in another society. For example, men who sit most of the day staring at the sun are considered to be exhibiting normal behavior in India where such men are believed to be holy. In the United States, the same men would probably be thought to be deranged, perhaps locked up, and/or referred to a psychiatrist. Normal behavior, therefore, can be defined as behavior which is socially acceptable in the individual's society. Another example of normal behavior involves driving an automobile. A driver in the United States automatically drives on the right side of the road (unless otherwise directed)--normal behavior. Driving a car on the right side of the road in England would not be normal behavior since that group of people drive on the left side of the road.

b. **Characteristics of Normal Behavior.** Although it is very difficult to define normal behavior, it is possible to list some characteristics of normal behavior. An individual who behaves normally has the following attributes:

(1) He is capable of changing his actions as the situation requires.

(2) He has insight into cause and effect. He is able to understand that the cause of his dented car fender was running the red light and, consequently, being hit by another car.

(3) He is oriented to time, place, and person. He may not know the exact date without looking at a calendar, but he does know the month, year, and where he is. His perception of reality is such that he knows who he is (not Napoleon, but Bob Jones, for example).

(4) He may or may not know why he behaves as he does at all times (usually he knows why).

(5) His motivations are purposeful. He does not wander aimlessly through life but is in control of himself and his environment. Major plans may include renting an apartment and then buying a house in the future. More immediate plans may be to go to a movie this weekend with friends for entertainment and relaxation.

1-3. DEFENSE MECHANISMS

a. **Definition.** Defense mechanisms are mental maneuvers, conscious or subconscious, performed by the ego (one's self) in order to decrease feelings of anxiety or stress. We live in a complicated world full of many pleasurable events but also full of strains and hassles. Life strains include chronic conditions of living that are unsatisfactory such as boredom, continuing family tension, job dissatisfaction, and loneliness. Hassles include irritating, frustrating, or distressing incidents that occur in everyday life such as disagreements with fellow workers, unpleasant surprises such as traffic tickets, and losing a wallet with all your credit cards. Defense mechanisms are man's way of dealing with the stress--good or bad--of living.

b. **Specific Defense Mechanisms.**

(1) Denial of reality. This is the simplest and most basic of all defense mechanisms. It is the attempt to blank out any disagreeable reality by ignoring it or refusing to acknowledge it. Example: A smoker concludes that the evidence linking cigarette use to health problems is not scientifically accurate.

(2) Repression. In this defense mechanism, the individual uses "selected forgetting." Threatening or painful thoughts and desires are excluded from his consciousness. Example: A subordinate "forgets" to tell his supervisor the circumstances of an embarrassing situation.

(3) Rationalization. An individual justifies his inconsistent or undesirable behavior by thinking up "explanations" which on the surface seem logical but, when examined, are illogical. Example: An account executive pads his expense account because "everybody does it."

(4) Fantasy. Daydreaming or other forms of imaginative activity allow an escape from the real world. Example: An employee dreams of the day in the staff meeting when he corrects his boss's mistakes and is publicly acknowledged as the real leader of the unit. Or, a student does poorly on a test and blames the instructor rather than his lack of studying.

(5) Projection. A person protects himself from the awareness of his own undesirable traits or unacceptable feelings by charging these traits or feelings are characteristic of someone else. Example: An expansionist- minded dictator of a totalitarian country (absolute control by this dictator) believes neighboring countries are planning to invade his country.

(6) Overcompensation. A person covers up a weakness by overemphasizing some desirable characteristic or making up for frustration in one area by overgratification in another area. Example: A dangerously overweight person goes on eating binges when something disappoints him or makes him unhappy. He gets a "Dear John" letter; he eats. The weather is bad, and he can't go to the coast; he eats.

(7) Conversion. An individual has emotional conflicts which are expressed in muscular, sensory, or bodily symptoms of disability, malfunctioning, or pain. Example: An individual puts in many hours of hard work on a project. The boss rejects the project, and the individual develops a major headache which forces him to leave work and go home.

(8) Identification. A person tries to raise his own self-esteem by patterning his behavior after the behavior of another person, often his boss. The person may accept his boss's values and beliefs and even vicariously share his boss's victories and defeats. Example: The "assistant" takes on the vocabulary, mannerisms, or even pomposity of his boss.

(9) Regression. A person returns to reaction patterns he has long since outgrown. Example: A manager, blocked from some highly visible project, busies himself with clerical duties or technical detail, work which someone he supervises should do.

(10) Emotional insulation. Characteristics of this defense mechanism include resignation, apathy, and boredom. The individual breaks emotional involvement with the environment; he draws back from any emotional or personal involvement. Example: An employee, receiving no reward, praise, or encouragement, no longer cares whether or not he does a good job.

(11) Reaction formation. The individual suppresses his real thoughts and attitudes (the ones which are unacceptable in his group) and vigorously supports the opposite attitudes (ones which are acceptable in his group). Example: An employee who has not been promoted overdoes the defense of his boss, vigorously upholding the company's policies.

(12) Displacement. An individual can't direct impulses at the appropriate target; therefore, he directs his impulses at a substitute target. Example: A person has many frustrations at work and really feels angry with his co-workers. He is in no position to tell them how furious he is, so he comes home and launches a verbal tirade at his wife and children.

(13) Ritualistic behavior. Some little act performed by the individual will magically, he thinks, make everything turn out all right. Example: A teenager who feels guilty about something he continually does but which he knows is wrong may touch door knobs a certain number of times each time after he commits the action. Or, a baseball player may cross himself each time he comes up to bat.

(14) Negativism. An individual actively or passively resists ideas without consciously realizing he is doing so. Example: A manager has been unsuccessful in being excused from a committee assignment. At the committee meeting, he picks apart every suggestion that anyone makes.

NOTE: Defense mechanisms begin to operate spontaneously and unconsciously when the self is threatened. If there are too many emergencies for the self, the self may overuse defense mechanisms with the result that the person does not really see reality. We all rationalize occasionally, and that is a good thing because rationalization can reduce stress. It is not a good thing to base all our judgments consistently on rationalizations; that would be overuse.

1-4. NEUROTIC BEHAVIOR

a. **Definition.** The word neurosis can be defined as emotional maladjustments which damage the individual's ability to think and make proper judgments but which cause minimal loss of contact with reality. The behavior of such a person is termed neurotic behavior. For a person exhibiting neurotic behavior, the usual ways of coping with daily living are proving inadequate, and the person is relying more and more on extreme defensive reactions. These defense reactions may help temporarily, but in the long run they are unsatisfactory. Types of neuroses covered in this lesson include the following: anxiety neurosis, hysterical neurosis, phobic neurosis, and depressive neurosis.

b. **Anxiety Neurosis.** An individual suffering from anxiety neurosis has exaggerated uncontrollable anxiety and apprehension. Anxiety disorders are fairly common in our society. Roughly two to four percent of the population has been diagnosed, at one time or another, as having some type of anxiety disorder. Signs and symptoms include a rather constant state of tension, worry, and general uneasiness. Such individuals are often oversensitive in people-to- people relationships and frequently have feelings of inadequacy and depression. Emotional tension frequently leads to physical tensions which cause neck and upper shoulder muscular pain and sleep disturbances of insomnia and nightmares. Decision making is difficult, and after the decision is made, the individual may worry excessively over possible disasters that may occur. Obsessive-compulsive disorders are examples of anxiety neuroses. An obsessive-compulsive person feels he must do something even though he does not want to do the thing. For example, a compulsion to wash his hands, though there is no logical reason to do so, is typical of a person exhibiting obsessive-compulsive behavior.

c. **Hysterical Neurosis.** In this type of neurosis, the individual loses emotional control, or develops some physical symptoms, when there seems to be no underlying cause for either. For example, student aviators have been found to develop vision problems and hearing problems as well as partial numbness of the tongue although there was no physical reason for such symptoms. The symptoms, examples of hysterical neurosis, were unwittingly developed by the students as a defense mechanism to a stressful situation. Physical illness gave the students an acceptable way to stop flying. Just leaving the flight training program was obviously not acceptable to these students.

d. **Phobic Neurosis.** A phobic neurosis is a persistent fear of some object or situation that is no real danger to the person or a situation in which the person magnifies a danger out of all proportion to reality. Phobic neuroses should not be confused with normal fears. Most people have minor, irrational fears from time to time, but phobic fears are intense and interfere with everyday activities. For example, people with phobic fears may go to great lengths to avoid going into a small room or passageway even when it is necessary for them to do so. Phobia sufferers often admit they have no real reason to be afraid of an object or situation, but they say they cannot help themselves. There are a wide range of symptoms of phobic fears. Included are the following: tension headaches, back pains, stomach upsets, and dizzy spells. Acute feelings of panic and feelings of unreality or strangeness often occur. Here is a list of common phobic neuroses:

(1) Acrophobia--fear of high places.

(2) Agoraphobia--fear of open places.

(3) Algophobia--fear of pain.

(4) Astraphobia--fear of storms, thunder, and lighting.

(5) Claustrophobia--fear of closed places.

(6) Hematophobia--fear of blood.

(7) Mysophobia--fear of contamination or germs.

(8) Monophobia--fear of being alone.

(9) Nyctophobia--fear of darkness.

(10) Ochlophobia--fear of crowds.

(11) Pathophobia--fear of disease.

(12) Syphilophobia--fear of syphilis.

e. **Depressive Neurosis.** It is difficult to distinguish between "normal depression" and "abnormal depression" which could be termed depressive neurosis. From time to time, very well adjusted people feel sad, discouraged, pessimistic, and a sense of hopelessness. When these feelings all come together, we say we have the "blues." Such feelings usually go away on their own and we get on with our lives. A state of neurotic depression is different in that this type of depression is more severe and lasts longer. Additionally, a person suffering from a depressive neurosis does not bounce back to normal after a reasonable period of time. Usually, a traumatic event led to the depression, an event the person can relate. A patient may exhibit the following signs and symptoms:

(1) A high level of anxiety.

(2) Apprehensiveness.

(3) Much less activity.

(4) Loss of self-confidence.

(5) Fewer interests.

(6) General loss of initiative.

1-5. PSYCHOTIC BEHAVIOR

a. **Definition.** Just as there is no real line between "normal" and "neurotic" behavior, there is no definite line between "neurotic" and "psychotic" behavior. A person suffering from psychosis has a severe mental illness marked by loss of contact with reality. On the other hand, the person suffering from a neurosis has only a minimal loss of contact with reality but has emotional problems that may impair his thinking and judgment.

b. **Characteristics.** Among typical characteristics of psychotic behavior shown by the psychotic person are the following:

(1) Inability to relate to reality.

(2) Inability to differentiate between the real and the unreal.

(3) Usually, complete loss of insight.

c. **Cause of Psychoses.** Four types of psychoses are associated with physical conditions: alcoholic psychosis; drug or poison intoxification; fever or infection; and cerebral conditions.

(1) Alcoholic psychosis. There are several alcoholic psychoses. They are pathological intoxication, delirium tremens, and acute alcoholic hallucinosis. These conditions are classified as psychoses because there is a temporary loss of contact with reality. Individuals who experience these conditions may have reactions which last only a short period of time. During such time, these individuals are confused, excited, and delirious.

(a) Pathological intoxication. This condition, an acute reaction, occurs in people with a low alcohol tolerance. The condition can also occur in someone whose alcohol tolerance is low at the moment from such causes as exhaustion, emotional stress, or other conditions. For these individuals, consuming even moderate amounts of alcohol can cause the person to suddenly become disoriented and go into a homicidal rage. Following the confused, disoriented state, the person usually falls into a deep sleep after which he may not remember anything that happened during the time he was confused.

(b) Delirium tremens. Otherwise known as the DTs, delirium tremens is an acute mental illness, a psychotic reaction sometimes caused by withdrawal from alcohol. A prolonged alcoholic binge, a head injury, or an infection may also trigger delirium tremens. Today, complications from delirium tremens can be treated with drugs, but half a century ago the death rate from DTs was approximately 10%. Signs and symptoms of this condition include the following:

1 Feeling of disorientation of time and place. Patient may believe he is in a church or jail, will not recognize old friends, but will believe hospital attendants are old friends.

2 Vivid hallucinations. An individual may think he sees small, fast-moving animals like snakes, rats, and roaches.

3 Acute fear. A person may see these small animals change in form, size, or color in terrifying ways.

4 Tremors. Marked tremors of hands, tongue, and lips. Hands, tongue, and lips shake uncontrollably and strongly.

(c) Acute alcoholic hallucinosis. In this condition, the patient appears normal, but he hears a voice. Initially, there is one voice making simple statements. Eventually, there are several voices issuing statements which are criticizing or reproaching the person. These voices attack the person's most private thoughts, list and discuss the thoughts, and propose punishments. This condition may last several days or several weeks during which time the patient is depressed but otherwise relatively normal. The psychotic symptoms experienced by the person seem to be triggered by alcohol, but he may have a broad range of inappropriate behavior not part of the acute alcoholic hallucinosis.

(2) Drug or poison intoxication. Both drugs and poison can act as intoxicating agents (intoxicants) causing psychosis (loss of contact with reality). For example, bromides were introduced in the 1850s, quickly became popular as sedatives, and were used (sometimes abused) by millions of people. It was discovered that those who used bromides too much reacted psychotically. These users had delusions, hallucinations, and a wide variety of neurological disturbances. Users of a modern day drug, LSD, behave psychotically. LSD users have set themselves on fire, jumped from high places, and one person drilled a hole in his head with a dental drill--all psychotic acts. Cocaine laced with rat poison has been reported to intoxicate psychotically and sometimes fatally.

(3) Fever and/or infection. Both a high fever and/or a severe infection can cause behavioral changes which can be psychotic in nature. Syphilis, encephalitis, and meningitis are such diseases. An individual with an untreated case of syphilis undergoes both physical and psychological (personality) changes. These changes range from becoming careless and inattentive in the disease's initial stages to spending money on impossible schemes as well as performing antisocial acts publicly in later stages of the disease.

(4) Cerebral conditions. A cerebrovascular accident, brain trauma, brain tumor, or cerebral arteriosclerosis can result in psychotic behavior. Damage or even small pressure in the brain may cause marked pressure and cause impairment of the normal functioning of the brain. Damage may cause hallucinations and a general impairment in the individual's intellectual processes with the result that he loses touch with reality, behaving psychotically.

d. **Schizophrenia.**

(1) Definition. This is a term used for a group of psychotic disorders whose chief characteristics include gross distortions of reality; withdrawal from dealing with other people (social interaction); and disorganization of perception, thought, and emotion. In other words, the schizophrenic has disturbances in thinking, mood, and behavior. The word schizophrenia means "split mind" and was initially given to this group of disorders because it was thought that these mental disorders were caused by a conflict between the mind and the emotions. Thinking today is that there may be several kinds of schizophrenias with many different causes. There may be biological causes of schizophrenia, and there may be environmental causes of schizophrenia.

(2) General symptoms of schizophrenia. Regardless of the type of schizophrenia, the basic experience is one of disorganization in perception, thought, and emotion. There are specific symptoms which may develop over a period of time and which vary in seriousness from person to person. Such symptoms include the following:

(a) Disorganization in an area of previous functioning. The person has been able to work, carry on social relations, and take care of himself in general. He becomes unable to get organized to do any of these.

(b) Language and communication disturbance. This symptom is sometimes called the "formal thought disorder." The individual does not lack education or ability but seems to put words together in an illogical order. For example, "I'm growing my father's hair." He meant something different obviously.

(c) Sense of self. The individual is usually confused about his identity, even whether he is male or female. He may believe that he is being controlled by "cosmic" or "oceanic" powers.

(d) Perception. The individual seems unable to sort out all the information which comes to him through the senses. Typical reactions are that he feels too alert, everything seems to be pouring in at once, his nerves are supersensitive, objects seem brighter, noises are louder.

(3) Specific symptoms of schizophrenia. These symptoms may vary from individual to individual.

(a) Disturbances of thought, speech, activity. Words may be in the wrong order, and thoughts may be composed of sentence fragments. This reflects the confusion in the person's thought processes.

(b) Inappropriate emotional responses. The person can appear emotionally cold; happy news does not bring forth joy in the schizophrenic person. Sometimes the schizophrenic makes inappropriate responses. For example, the person is told of the death of a loved one and laughs.

(c) Withdrawal. The individual physically and/or psychologically may pull back from interaction with other people and/or from his environment. Withdrawal is a coping mechanism and is an individual's way of coping with the stress he sees in his world.

(d) Regression. Those who cope by regressing revert to an earlier type of behavior in order to deal with the situation at hand. The earlier behavior is characteristic of an earlier level of development. For example, an adult might resort to behavior typical of his teenage years.

(e) Delusions. A delusion may be defined as a fixed false belief. Types of delusions include paranoid delusions, grandiose delusions, somatic delusions, and delusions of poverty. Paranoid delusions are delusions in which the individual believes someone is out to get him (although this is not true). A person with grandiose delusions (delusions of grandeur) may believe he is a sports hero, a famous political leader, or someone all-powerful like God. An individual with somatic delusions focuses on his body and is convinced that he is the victim of a frightening disease. A person with delusions of poverty is convinced that he is penniless and responsible for the downfall of his family (although this is not true).

(f) Hallucinations. The schizophrenic person may hear, taste, see, smell, or feel things that are not there.

1-6. PERSONALITY DISORDERS

Throughout their lives, people continually develop and change as required by the changing demands, opportunities, and limitations which accompany different stages of life. As an individual grows, however, certain broad traits, coping styles, and ways of behaving socially tend to emerge. By the time a person has completed the teen years, he has developed his own unique ways of dealing with life situations. These ways or patterns are his personality. An adult personality is usually able to deal effectively with the society in which he lives. In contrast, there are some individuals whose personality development has been warped. These individuals cannot live comfortably in any society. Such individuals have a personality disorder. Typical personality disorders are not caused by stress or anxiety but rather by immature and distorted personality development.

a. **Paranoid Personality.** The person who is paranoid feels singled out and taken advantage of, mistreated, plotted against, stolen from, spied upon, ignored, or otherwise mistreated by "enemies." These feelings are delusions. In truth, no one is "out to get" the person. Characteristics of the paranoid personality include the following:

(1) Hypersensitive.

(2) Rigid.

(3) Suspicious.

(4) Jealous.

(5) Envious.

(6) Exaggerated sense of own importance.

(7) Tendency to blame others.

NOTE: Paranoia does not seem to interfere with the rest of the individual's personality. Aside from the area of paranoia, an individual may be able to function very well in a highly organized manner.

b. **Cyclothymic Personality.** This mild personality disorder is characterized by extreme mood swings from elation to depression. The mood swings, however, are not disabling to the individual. The individual may feel exhilarated and outgoing with a high energy level-- hypomanic behavior. On the other hand, he may feel melancholy with a mild, depressive-like state. He feels lonely, sympathetic, kind, quiet, and a little sorry for himself.

NOTE: In stressful situations or even for no apparent reason, the cyclothymic personality may develop into manic-depressive psychosis (extreme psychotic disorder characterized by long periods of overexcitement and overactivity and/or long periods of depression and underactivity).

c. **Schizoid Personality.** This is a personality characterized by shyness, oversensitivity, seclusiveness, and eccentricity in communication and behavior. An example of schizoid personality is an adult who has a life pattern of social isolation (little or no interaction with other people). He is distant and somewhat distrustful of other people, rather fearful, and sensitive. Instead of dealing with people, he concentrates on nonpeople details of his life such as the meaning of "Wash before wearing" on a new pair of jeans. Does this mean wash the jeans before wearing the first time or, for some reason, do the jeans need to be washed each time before they are worn? He considers this question for several days. This type of dilemma is comfortable for the individual with a schizoid personality because the problem requires no interaction with any other person.

d. **Explosive Personality.** The distinguishing feature of this personality is frequent, sudden outbursts of aggression. Especially under pressure, an individual with this type of personality becomes overly excitable and overresponsive.

e. **Obsessive-Compulsive Personality.** Obsession can be defined as a persistent preoccupation with something--an idea or a feeling. A compulsion can be defined as an irresistible impulse. An individual with an obsessive-compulsive personality feels compelled to think about something that he does not want to think about, or to carry out some action against his will. People with this type of personality usually realize that their behavior is irrational, but they feel they can't stop the behavior. Characteristics of this type of personality include the following:

(1) Rigid.

(2) Punctilious (strict observance of formalities or conduct).

(3) Fastidious (hard to please; much too critical and demanding).

(4) Very formal.

(5) Overly conscientious.

f. **Hysterical Personality.** An individual with this type of personality exhibits the following characteristics:

(1) Vain.

(2) Self-indulgent.

(3) Overly-dramatic.

(4) Exhibitionistic.

g. **Asthemic Personality.** The following characteristics are typical of this type of personality:

(1) Easily tired.

(2) Low energy level.

(3) Lack of enthusiasm.

(4) Diminished capacity for enjoyment.

(5) Oversensitive to stress.

(6) May develop into the personality disorder neurasthenic neurosis (a neurotic disorder characterized by complaints of chronic weakness, easily tired, and lack of enthusiasm).

h. **Antisocial Personality (Psychopath--Sociopath).** The antisocial personality is characterized by a lack of ethical or moral development and an apparent inability of the person to follow approved models of behavior. Psychopath and sociopath are both terms for an antisocial personality. Both may be defined as a personality disorder involving a marked lack of ethical or moral development. A psychopath exhibits characteristics such as a disregard for the rules of society, immaturity, difficulty in postponing gratification, poor control of impulses, and little ability to consider the consequences of his actions. The individual with this type of personality could want a new car; steal a new car, shoot the security guard in the process, and feel no guilt. This type of person would find it intolerable to work at a job, save money, and buy the new car in the future. He wants pleasure now without considering the past or the future.

i. **Passive-Aggressive Personality.** Individuals with this type of personality typically express hostility in indirect and nonviolent ways; in other words, passively. Characteristics of such an individual include procrastinating (why do today what you can put off until tomorrow); "forgetting;" deliberately keeping something from being done; inefficiency. This type of behavior is more often present in work situations but can be present in situations with other people. The passive-aggressive personality never really confronts a problem directly, behavior which results in no problem solving at all.

j. **Inadequate Personality.** Characteristics typical of this type of personality include:

(1) Normal intellectual endowment.

(2) Ineffectual.

(3) Inept.

(4) Unconcerned with reaching set goals.

k. **Passive-Dependent Personality.** This type of personality is extremely dependent on other people and suffers acute discomfort-- almost panic--at having to be alone. Self-confidence is lacking, and such individuals feel helpless working by themselves even though they may be very competent and have good work skills. A listing of characteristics typical of the passive-dependent personality includes:

(1) Absence of self-confidence.

(2) Immature personality.

(3) Overwhelmed by feelings of helplessness, fear, and indecision.

(4) Clings to others for support.

1-7. THERAPEUTIC INTERVENTIONS

Today, mental health professions are concentrating on preventing mental health problems. In the 1960s, individuals with mental health problems were usually seen only after the problem became severe. Typically, the person was sent far away from their home area to recover. If treatment is necessary today, the person is treated in the area in which he lives so that not only will his life be disrupted as little as possible but also he will be able to keep in contact with his support groups--his family and his friends. Additionally, a patient who must be placed in a hospital is returned to the community as soon as possible so that his problem will not become chronic.

a. **Psychotherapy.** The definition of psychotherapy is the treatment of mental disorders by psychological methods. Almost everyone has had the experience of being helped by some advice from a relative or friend. Sometimes an experience has prompted us to make a drastic change in our lives. Psychotherapy is very close to the advice or the experience that caused us to make a change in our lives. A basic assumption in psychotherapy is that the individual with a personality problem can change. He can learn more effective ways of perceiving, evaluating, and behaving so that he will be able to function in society more effectively and happily. General goals of psychotherapy include these steps:

(1) Change in patterns of behavior which are maladaptive; that is, behavior which is detrimental to the well-being of the individual and/or group.

(2) Improving the individual's ability to deal with other people.

(3) Resolving the person's inner conflicts and thus reducing his personal distress.

(4) Changing the person's inaccurate assumptions about himself and the world around him.

(5) Helping the person achieve a clear sense of who he is.

NOTE: All of the above will help the troubled person toward a more meaningful and fulfilling life.

b. **Drugs Commonly Used in Treatment of Mental Illness.** One of the medical profession's long term goals has been to discover drugs that can combat mental disorders effectively. In years past, research centered on medications that would have soothing, calming, or sleep-inducing effects. These drugs would help manage distraught, excited, and the sometimes violent patient. Current research has focused on development of drugs that will allow the troubled person to lead a more normal life rather than just sedate him. Major tranquilizers include chlorpromazine (Thorazine®), thioridazine (Mellaril®), and trifluoperazine (Stellazine®). Other drugs used to treat mental disorders include lithium carbonate (an antimaniac agent) and minor tranquilizers (antianxiety agents) such as Librium®, Valium®, Vistaril®, and Miltown®.

Continue with Exercises

EXERCISES, LESSON 1

INSTRUCTIONS. The following exercises are to be answered by completing the incomplete statement or by writing the answer in the space provided. After you have completed all the exercises, turn to the solutions located at the end of the exercises and check your answers.

1. Normal behavior, as defined in this lesson, is _____

   _____.

2. List three characteristics of normal behavior.

   a. _____.

   b. _____.

   c. _____.

3. Specialist MacDonald is in school being trained in a new MOS. He studied very little for the last examination and received a low score. He complains that he received a low test score because the instructor made the test too hard.

   Specialist MacDonald is using the defense mechanism _____.

4. Mr. Jenkins daydreams at work. His favorite daydream is the one in which he corrects his boss's mistakes during a staff meeting and is publicly acclaimed as the leader of the group of people. The defense mechanism he is using is

   _____.

5. Adam Mills can only be described as obese; he weighs at least 100 pounds more than he should. When he is disappointed or unhappy (despite his overweight condition), he goes on eating binges. The defense mechanism he is using is termed _____.

6. Ross Hunter did not win a promotion which he worked very hard for and which he thought he deserved. Ross constantly defends his new boss, too much. Ross, additionally, now defends the company's policies more vigorously than he ever did before. The defense mechanism he is using is called _____.

7. Neurosis, as defined in this lesson, is _____

   _____

   _____.

8. Mark Dalton constantly washes his hands although there is no real reason to do so. He is suffering from _____ disorder, a type of anxiety neurosis.

9. Studies have found that sometimes students in flight school develop partial numbness of the tongue while other flight school students develop trouble seeing. Physical examinations reveal that there is no physical reason for these afflictions. The students are probably suffering from a condition called _____neurosis.

10. Cecily Hunter has an abnormal fear of high places. Walking on a footbridge across a river is something she can't do. Her fear of high places is called _____; it is one of the _____ neuroses.

11. Nick Timberlane is abnormally uncomfortable in crowds. Being in a mob of people at a rock concert is beyond him. He suffers from the disorder of _____.

12. List three specific symptoms of schizophrenia.

    a. _____.

    b. _____.

    c. _____.

13. Drugs are commonly used in the treatment of mental illnesses. In past years, drugs have been used to calm and sedate the patient. Research today is focused on discovering drugs that will help the mentally-ill patient lead _____.

14. The definition of psychotherapy, as given in this lesson, is _____ _____ .

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 1

1. Behavior which is considered socially acceptable in the individual's society. (para 1-2a)

2. You are correct if you listed any three of the following:
   Capable of changing actions.
   Has insight into cause and effect.
   Oriented to time, place, and person.
   May or may not know why he behaves as
   He does at all times.
   Motivations are purposeful. (para 1-2b)

3. Rationalization. (para 1-3b(3))

4. Fantasy. (para 1-3b(4))

5. Overcompensation. (para 1-3b(6))

6. Reaction formation. (para 1-3b(11))

7. Emotional maladjustment(s) which damage the individual's ability to think and make proper judgements but which cause a minimal loss of contact with reality. (para 1-4a)

8. Obsessive-compulsive. (para 1-4b)

9. Hysterical. (para 1-4c)

10. Acrophobia. Phobic. (para 1-4d)

11. Ochlophobia. (para 1-4d)

12. You are correct if you listed any three of the following:
    Disturbances of thought, speech, activity.
    Inappropriate emotional responses.
    Withdrawal.
    Regression.
    Delusions.
    Hallucinations. (para 1-5d)

13. A more normal life rather than just sedate him. (para 1-7b)

14. The treatment of mental disorders by psychological methods. (para 1-7a)

End of Lesson 1

LESSON ASSIGNMENT

LESSON 2	Burnout, Depression, and Suicide.
LESSON ASSIGNMENT	Paragraphs 2-1 through 2-5.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

2-1. Define and identify the causes of burnout.

2-2. Identify the symptoms and preventive techniques for burnout.

2-3. Identify two major types of depression.

2-4. Identify the signs/symptoms of severe depression.

2-5. Identify the techniques and drugs used for the management of depression.

2-6. Identify circumstances which aid in the identification of potential suicide victims.

2-7. Identify the factors which differentiate a suicide gesture from a suicide attempt.

2-8. Identify the methods of managing a potential suicide victim.

SUGGESTION After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 2

BURNOUT, DEPRESSION, AND SUICIDE

2-1. INTRODUCTION

Burnout, depression, and suicide occur much more often than most people realize. Unrelieved burnout can lead to depression, and prolonged depression will often lead to suicide or at least to the planning of suicide. In a combat situation, this deadly chain of psychiatric illness can cost the lives of many soldiers and seriously endanger the mission. As a first line medical care provider, it is your job to recognize the symptoms of burnout and depression, and provide or refer the patient for medical care so that suicide does not happen. Depending on the type and the severity of the symptoms, you may need to refer a patient back from the front line for extended inpatient treatment. This lesson will provide the information you need to make this kind of decision.

2-2. BURNOUT

a. **Definition.** Burnout can be defined as a state of physical and emotional exhaustion in which one feels a negative self-concept and negative attitude toward his job. Burnout is a symptom that suggests that a person's job expectations are higher than reality. Burnout is the attitude that "a job is a job is a job." Burnout is often seen among individuals in the health care setting because these individuals are very idealistic. They want to save the world from disease and death; not everyone can be saved.

b. **Causes: General.** There are a variety of causes of burnout. Some causes come from inside the person--internal causes. A person may set unrealistically high goals. He is totally committed to the job, a perfectionist who wants to tackle all the problems himself, and takes on all possible responsibilities. Once he finds that there are simply not enough hours in the day for him to do everything perfectly, he experiences burnout. Other internal causes of burnout include personal problems: domestic problems (trouble at home); stress in a personal relationship; etc. Sometimes the chief causes of burnout come from outside the individual --external causes. Included in this classification are:

(1) Overwork.

(2) Shortage of staff and supplies.

(3) Unresponsive leadership.

(4) Lack of group cohesiveness (or no esprit de corps).

(5) Lack of recognition for a job well done.

(6) Short-fused suspenses.

(7) Lack of resources.

(8) Lack of rewards.

c. **Causes: Burnout in the Military.** There are characteristics of military life that some people find frustrating and upsetting. For some, family separations and frequent moves are external factors that contribute to burnout. There may be a feeling of isolation from society in general. Frequent changes in staff can cause a lack of feeling of group cohesiveness. The combination of these four elements sometimes produces a feeling of hopelessness, ending in burnout.

d. **Burnout in Combat (Battle Fatigue)**. Burnout in combat and battle fatigue are deliberately nondescriptive names for a wide variety of behaviors, mental symptoms, and physical symptoms which can happen to any soldier. The basic causes are the many stresses a soldier is subject to in combat. What happens is that these stresses temporarily overwhelm and short circuit the individual's psychological defenses; the result is a type of burnout. Causes of combat burnout include the following:

(2) Fear of death or injury.

(3) Lack of preparation or training.

(4) Fear of failure or losing face in combat.

(5) Lack of adequate rest and/or nutrition.

(6) Lack of adequate sanitation.

(7) Feeling of facing overwhelming odds.

(8) Long periods of an extremely high stress situation without relief.

e. **Signs/Symptoms of Burnout.** Included are the following:

(1) Physical and mental exhaustion. The person gets tired very easily.

(2) Less production/enjoyment at work. The person seems to work harder, but he is producing less and enjoying the work less.

(3) Disenchanted with work and life. The individual may be a chronic complainer.

(4) Unexplained depressions.

(5) Irritable and short-tempered.

(6) Impotent or lack of sexual desire.

(7) Less contact with co-workers. The individual does not enjoy talking and being with others at work.

(8) More physical complaints.

(9) Inability to relax and enjoy free time.

(10) Withdrawn and quiet with little to say.

(11) Absentminded.

(12) Increased drug or alcohol consumption. A teetotaler may begin to drink.

(13) Decreased social interaction with family and friends. He withdraws, is preoccupied and moody when with family and friends, is unable to share or talk about his frustrations with these people. The burnout sufferer will state that no one wants to listen to his problems. On the other hand, when someone asks him directly about what is troubling him, he will respond either that he doesn't want to talk about work or that the person who asked wouldn't understand.

f. **Techniques to Prevent Burnout.** There are several techniques used to prevent burnout. Here are some techniques which you can use to prevent burnout for yourself or which you can recommend to someone else:

(1) Monitor yourself. Be alert to changes in your body or normal habits.

(2) Communicate. If you find yourself withdrawing, force yourself to be out-going with other people. Do not retreat within yourself and build a prison of loneliness.

(3) Listen to your "inner self." Understand yourself.

(4) Obtain feedback from coworkers or contemporaries. Your strongest support may be among your coworkers. When work becomes a topic for social discussion, learn to discuss it until everyone has had a say. Decide what can be done, and, then, change the subject.

(5) Actively develop and foster an "esprit de corps" in your unit. If you are a manager and are trying to prevent burnout in your unit, try to develop a sense of togetherness in the unit. Studies have shown that individuals with a highly developed sense of togetherness and spirit suffer from burnout less often than those without this characteristic.

(6) Do not try to be perfect. You are only human. Stop expecting too much of yourself.

(7) Set realistic goals. It is stimulating to set high goals. If, however, these goals cannot be reached and this fact bothers you, set goals that can be met.

(8) Focus on one thing at a time. Do not try to do everything at once. Do not try to be everything to everyone.

(9) Learn to relax. Leave work at work. Do not take unnecessary paperwork home every night and on weekends. Plan to take vacations away from your working area. Go to the mountains or the coast for a few days every couple of months. Take a break at specific intervals to "recharge your batteries." You can also learn and practice relaxation techniques. This does not mean getting extra sleep. Yoga is one relaxation technique, but other approaches are available, simple, and beneficial.

(10) Develop outside interests. Be sure there is something else in your life in addition to work. Active sports such as baseball, volleyball, skiing, bowling, swimming, etc., are good relaxers for some people. Other individuals find enjoyment in music, reading, writing, painting, etc. Whether you have a passion for stamp collecting or scuba diving, an interest not connected with work will give you something else to think about as well as something else to talk about.

2-3. DEPRESSION

a. **Definition.** This type of depression is a mood disturbance which is so severe that the individual needs some type of help. Depression can be defined as a mental state characterized by feelings of sadness, despair, unhappiness, worthlessness, and hopelessness. Everyone has mood changes: sometimes feeling great and at other times feeling a little down. Usually, we can swing up out of our depressed states by ourselves. When a person's depression becomes such that the individual cannot function or is a danger to society, that depression has moved out of the normal range. The individual must have professional help.

b. **Types of Depression.** Depression may be classified as either exogenous or endogenous. Exogenous depression is often referred to as situational depression because it comes from something outside the person. Possible causes include the loss of a loved one (death or departure of a parent or child); loss of self-esteem due to business failure, rejection, or divorce; or inability to express or admit anger toward others ("holding it in"). Endogenous depression just comes out of the blue and is not caused by any situation or event. It may be caused by a chemical imbalance in the brain. Much research in this area indicates that this type of depression may be due to some mental illness or even a dietary deficiency. Endogenous depression, the type that comes out of the blue, is more severe than exogenous depression. The patient may need to have psychiatric help immediately.

c. **Signs and Symptoms of Severe Depression: General.** There are a number of signs and symptoms of severe depression. Included are the following:

(1) Trouble with concentration and memory.

(2) Feelings of guilt about inconsequential events.

(3) Insomnia or excessive sleepiness.

(4) Feelings of hopelessness and worthlessness.

(5) Withdrawal from activities and interests.

(6) Decreased interactions with family and friends.

(7) Decreased work productivity.

(8) Decreased relationship with coworkers.

(9) Changes in bowel habits.

(10) Weight loss or gain.

(11) Decreased libido (sexual drive).

(12) Slowed speech and/or motor activity.

d. **Signs and Symptoms of Severe Depression: Symptom Clusters.** An individual suffering from severe depression will usually have more than just one sign or symptom. He may have several signs/symptoms--a cluster of signs/symptoms.

(1) Exogenous depression. A typical symptom cluster for exogenous depression includes:

(a) Precipitating event.

(b) Trouble getting to sleep at night.

(c) Feeling fine in the morning and getting worse as the day goes on.

(d) Weight loss of less than 10 pounds.

(e) Reaction to the environment--if the person is with an "up" crowd, he will seem to come out of his depression for a while.

(2) Endogenous depression. A typical symptom cluster for endogenous depression includes:

(a) Retardation of thought and motion (thinks in "slow motion").

(b) Substantial weight loss due to very poor appetite.

(c) Feeling that depression "crept upon him" and "came out of the blue."

(d) Wakes very early in the morning and can't get back to sleep.

(e) Feels worse in the morning and improves as the day goes on.

(f) Does not react to the environment.

(3) Evaluation. The evaluation of the symptom clusters requires you to inquire about specific symptoms such as weight loss and the amount of loss over a given period, sleeping patterns, and feeling of hopelessness. Arrange the symptoms into appropriate clusters if indicated. Patients may have components of more than one type of depression or other complicating mental illness.

e. **Management of Depression.** Types of medications used with severely disturbed depressive patients include antidepressant, tranquilizing, and antianxiety drugs. Usually, drug treatment is combined with other forms of therapy such as individual or group psychotherapy. Medications given to treat depression are classified in three groups: antianxiety, antidepressant, and antipsychotic agents.

(1) Antianxiety medication includes agents such as:

(a) Hydroxyzine (Atarax®, Vistaril®).

(b) Meprobamate (Equanil®, Miltown®).

(c) Chlordiazepoxide (Librium®).

(d) Diazepam (Valium®). Central nervous system (CNS) depressants producing mild sedation are included in antianxiety medication.

(2) Commonly used antidepressant agents include:

(a) Imipramine (Tofranil®).

(b) Amitriptyline (Elavil®).

(c) Amitriptyline and Perphenazine (Triavil®).

(d) Doxepin (Adapin®, Sinequan®). CNS depressants producing mild sedation are also included as antidepressants. Improvement of depression may take one to four weeks.

(3) Antipsychotic agents that are commonly used are:

(a) Thioridazine (Mellaril®).

(b) Haloperidol (Haldol®).

(c) Lithium (Lithane®, Lithonate®). CNS depressants used as antipsychotic agents are sedative or hypnotic and do not depress the vital centers.

(4) Generally, central nervous system depressants are NOT used to treat depression. Amphetamines (Benzedrine®) and Methylphenidates (Ritalin®) fall in this category.

2-4. SUICIDE

a. **Introduction.** Suicide is defined as the intentional taking of one's own life. A leading cause of death in most Western countries, it is estimated that over 200,000 persons in the United States attempt suicide each year. Of that number, about 26,000 are successful in their suicide attempt. The actual number of suicides may be higher since official records often list a suicide as another form of death.

b. **Suicide in the Army.** The United States Army is made up of people from all walks of life, people performing their duties all over the world. The demands of their mission place soldiers under unusual amounts of stress which sometimes leads to depression and then suicide attempts. Suicide ranks as one of the top ten killers among civilians and is one of the top three killers in the active duty peacetime military. Suicide is not more common in the peacetime Army. Soldiers are screened at the time of entry into the Army and are physically fit. Additionally, these individuals are serving in the Army during their peak years of physical fitness. Nevertheless, frequent moves, continually learning new tasks, and separation from family can take their toll. The most commonly used methods of suicide in the military have been firearms, poison such as carbon monoxide, and hanging. The highest rate of suicides in recent years has been among E-2s in the period between the completion of basic training and the start of the next duty assignment. This is a time of transition, with anticipation of pass/fail training assessments, moving, separation from friends, and disrupted personal relationships.

c. **Types of Suicidal Behavior.** Suicidal behavior is usually broken down into these types: suicide threats, suicide attempts, suicide gestures, and the successful suicide. The suicide threat usually takes place before an actual suicide attempt. Suicide threats include statements such as "I just can't take it anymore." or "Will you remember me when I'm gone?" or "Take care of my family for me." The suicide threat is an indication that the person can't make up his mind but is thinking of suicide. Suicide attempts include any actions taken by the individual toward himself that will lead to death if not interrupted. A suicide gesture is really a cry for help. The individual carefully thinks out the ways in which he may be rescued from his suicide attempt. His plans may include a call to someone to say that he has just taken an overdose of some medicine or a suicide attempt in a place where he will be found and rescued. The methods most frequently used in a suicide gesture are superficial cutting of wrists and single drug overdose. The successful suicide is, of course, the individual who tries and succeeds in taking his own life.

d. **Terms Relating to Potential Suicides.**

(1) Behavior signs. The person's actions or behaviors may suddenly change greatly. A very thrifty person may suddenly begin spending more money than he earns. A moderate drinker may increase his alcohol consumption.

(2) Crisis. This is the point at which the usual problem-solving or decision-making methods are no longer adequate. At this point, the person may be so overwhelmed that he selects suicide as the only way to solve his problems.

(3) Depression. Feelings (moods) of sadness, despair, and discouragement describe depression. Depression may be disruptive to the soldier causing decreased ability to think, diminished physical ability, guilt, self-condemnation, hopelessness, and disorders of eating and sleeping.

(4) Intervention. This term refers to treatment by health care personnel when there is some question of the individual's ability to cope by using his own resources. The person needs help. Crisis intervention is professional help when the person shows signs of reaching a crisis point.

(5) Stress. This is a normal pattern of mental and physiological responses to changing life circumstances. Even a favorable change--promotion or marriage--causes some stress to the individual.

(6) Stressors. The event or circumstance which causes stress is defined as the stressor.

(7) Suicide. Suicide is the act of taking one's own life voluntarily and intentionally.

e. **Causes of Suicide.** No one knows positively why people choose to kill themselves. An individual is usually so emotionally upset and overwhelmed that he wants to stop the pain of living. A person who is suicidal feels overwhelmingly lonely and isolated. He feels helpless, hopeless, and worthless. Such people often truly believe that it does not matter whether they live or die; if they were dead, no one would miss them. A suicidal individual feels that he cannot cope with his problems and that suicide is the only way out. Possible causes include the following:

(1) Ending of a close, personal relationship or difficulty with a relationship.

(2) Death of a loved one; spouse, child, parent, brother or sister, friend, or pet.

(3) Worry about job performance, fear of failure, or fear of doing less well than expected.

(4) Move to a new place causing loss of friends which made up a support system.

(5) Health problems, particularly those which interfere with job goals.

(6) Disorientation and other complications of excessive use of drugs and/or alcohol.

f. **Myths and Facts About Suicides.** There is a great deal of misinformation about suicides. Here are some of the more common myths and the facts.

(1) Myth: People who talk about suicide don't actually commit suicide.

Fact: About 80 percent of those people who talk about suicide attempt or commit suicide. A person who talks about suicide may be giving a warning that he may try suicide.

(2) Myth: A suicidal person will commit the act if he talks about his suicidal feelings to another person.

Fact: If you ask a suicidal person about his suicidal feelings, he will often feel relieved that someone finally realizes that he is in emotional difficulty. He will not commit the act just because you asked about his suicidal feelings.

(3) Myth: All suicidal people want to die, and there is nothing anyone can do about their death wish.

Fact: Most suicidal people are undecided about whether to live or die. They often call for help just before or just after a suicide attempt.

(4) Myth: Suicide is an impulsive act with no previous planning.

Fact: Not always. Most suicidal people have planned carefully and thought about the act for weeks.

(5) Myth: A person who attempts suicide will not try again.

Fact: The majority of people who commit suicide have tried before.

(6) Myth: The danger of suicide is over when the suicidal person begins to recover.

Fact: No. The majority of suicides occur within about three months after the person starts to improve. At this time, the individual has enough energy to act on his morbid thoughts and feelings. His desire to escape from life may be so great that the thought of suicide seems a relief from a hopeless situation. Frequently, the suicide follows a period when the individual has been very calm.

(7) Myth: Suicidal people are actually mentally ill.

Fact: Studies of many suicide notes reveal that the suicidal person is desperately unhappy, but that he is not necessarily mentally ill.

g. **Depression.** Depression has been discussed earlier in this lesson, but it is important to remember that depression is the single most outstanding characteristic of individuals who attempt suicide and suicide victims. Refer to paragraphs 2-3a through 2-3d for information on depression.

h. **Potential Suicides.** People most at risk as potential suicides include individuals who have:

(1) Made a previous attempt to commit suicide.

(2) A family history of suicide. (Suicide does not, however, run in the family.)

(3) Lost a friend recently through suicide.

(4) Been involved with drugs or alcohol.

(5) Alcoholics in the family.

i. **Psychosocial Symptoms of Potential Suicide.** Most people who commit suicide give clues that they are experiencing serious difficulties. Some of these clues are related to human emotions and a change in the life-pattern of the person. Many of these symptoms are caused by stress due to some current situation. Remember that a substance abuser may exhibit some of these same symptoms. The symptoms are:

(1) Depressed mood.

(a) Feels low, sad, gloomy.

(b) Expresses self-reproach, self-depreciation.

(c) Tearfulness and/or trembling.

(2) Change in appearance. Changes in appearance may indicate a person's mood and self-image.

(a) Neglect of hair and/or personal hygiene.

(b) Lack of concern for dress.

(c) Bodily movement slowed, decrease in gestures, stooped and bent posture.

(d) Facial expression may be blank, old, or sad.

(3) Change in work habits.

(a) Lowered quality/quantity.

(b) Inconsistent work pace. The work pace is likely to change frequently, without apparent reason.

(c) Compulsive worker.

(d) Lack of interest in work.

(4) Changes in usual patterns of behavior.

(a) Loss of interest in recreation/hobbies.

(b) Loss of interest in people. The individual may avoid family and friends and may also have a decreased sexual drive.

(5) Marital and family problems.

(a) Separation/divorce.

(b) Difficulties with spouse.

(c) Child-rearing problems.

(d) Loss of self-control.

(e) Social isolation.

(6) Financial problems.

(a) Debts.

(b) Living within a tight budget.

(7) Interpersonal problems.

(a) Lover's quarrels.

(b) Difficulty in accepting authority.

(c) Homesickness.

(d) Loss of supportive friends/family ties.

(e) Difficulty with people at work.

j. **Immediate Danger Signals of Suicide Intent.** One or more of the following signs seen in a person may indicate an immediate problem:

(1) Depressive symptoms . Included, but not limited to, are:

(a) Insomnia.

(b) Inability to concentrate.

(c) Loss of appetite.

(d) Apathy/social withdrawal.

(e) Poor personal hygiene/sloppiness.

(f) Crying.

(g) Feelings of worthlessness.

(2) Verbal warnings. The mythology surrounding suicide leads people to believe that the person who talks about suicide does not commit suicide. That is not true. Some examples of verbal warnings are:

(a) "I'm getting out," or "I'm tired of it all."

(b) "I wish I were dead."

(c) "I can't go on any longer."

(d) "If such and such happens (or doesn't happen), I'll kill myself."

(e) "You're going to regret how you've treated me."

(f) "Here, take this (valued possession). I won't be needing it anymore."

(3) Behavior warnings. A person may not make statements that indicate he is considering suicide. Instead, he may show through his behavior that he is suicidal. Some of these behavioral warnings are:

(a) Organizing personal-business matters as if he were going away for a long time.

(b) Planning his own funeral shortly after the death of a loved one.

(c) Suddenly resigning from clubs and church groups to which he belongs.

(d) Crying for no apparent reason.

(e) Composing a suicide note. These are sometimes found days before the suicide occurs.

(f) Attempted suicide is the strongest behavioral warning.

(g) Unexplained change from usual behavior patterns. A non- drinker begins drinking to excess. A person who hates guns suddenly buys one.

(h) Sudden, unexplained recovery from a severe depression. Some persons who have decided to kill themselves may appear quite happy. Actually, they are not happy but relieved because they have made the decision to kill themselves. You can not tell just by looking at the person.

k. **Management of the Potential Suicide.**

(1) When to intervene. The medical specialist should take appropriate intervention actions when an individual displays potentially suicidal behavior, or when a person is a clear and present danger to himself or to others.

(a) Communication with the patient should convey the message that you care about him. Assure the person that help is available, and you will assist him in getting that help.

(b) It is not easy to determine if a person is about to commit suicide. If you suspect that a soldier has suicidal intentions, refer him to specifically trained personnel, such as an MOS 91X (Mental Health Specialist).

(c) If an individual should confront a medical specialist with immediate means of suicide on his person, such as medication, a knife, or a gun, use caution in intervening so as not to endanger other people or yourself.

(2) Appropriate intervention actions. Do not leave an individual with suspected suicidal intentions alone at any time; he might kill himself. Notify your immediate supervisor or NCOIC of possible need for intervention. The following actions are appropriate:

(a) If physical and psychosocial symptoms along with verbal and behavioral warning signs are observed in the soldier, discuss the situation with the NCOIC or with personnel in accordance with local directives. If the person seems to be about to attempt suicide soon, contact professional medical personnel by emergency call and proceed in accordance with local directives.

(b) You may accompany the individual to a referral agency or to a consulting professional for assessment, or you may turn the individual over to the official in charge of transportation arranged for by professional personnel.

2-5. CLOSING

As a medical specialist, you should become familiar with and knowledgeable about potentially suicidal patients. Awareness of presuicidal symptoms and signs could lead to intervention and prevention of suicide. Surely all of us experience times in our lives when we simply cannot face another day. There are times when life just doesn't seem worth the agony and pain it forces us to endure. Yet, however "appropriate" and strong these feelings of utter hopelessness seem to be and the fleeting impulse to end it all, most of us don't give in to the impulse. The most important response to any suicide threat is to take it seriously--as if someone's life depended on your being concerned.

Continue with Exercises

EXERCISES, LESSON 2

INSTRUCTIONS. The following exercises are to be answered by completing the incomplete statement or by writing the answer in the space provided. After you have completed all the exercises, turn to the solutions located at the end of the exercises and check your answers.

1. Burnout, as defined in this lesson, is _____

   _____.

2. List four external causes of burnout.

   a. _____.

   b. _____.

   c. _____.

   d. _____.

3. List four characteristics of military life which contribute to burnout for some people.

   a. _____.

   b. _____.

   c. _____.

   d. _____.

4. List three possible causes of burnout in combat.

   a. _____.

   b. _____.

   c. _____.

5. List four signs/symptoms of burnout.

   a. _____.

   b. _____.

   c. _____.

   d. _____.

6. Learning and practicing relaxation techniques does not mean get extra sleep. It means getting away from work from time to time and not taking unnecessary paperwork _____ on week nights and/or weekends.

7. Depression can be defined as a mental state in which the person has feelings of sadness, _____, unhappiness, worthlessness, and _____.

8. List three signs/symptoms of severe depression.

   a. _____.

   b. _____.

   c. _____.

9. Types of medications commonly given to severely depressed patients include antianxiety medications, _____ agents, and _____agents.

10. Suicide may be defined as the act of taking one's own life _____ and _____.

11. List three possible causes of suicide.

    a. _____.

    b. _____.

    c. _____.

12. Is it a myth or fact that people who talk about suicide don't actually commit suicide? _____.

13. Is it a myth or fact that suicidal people want to die, and there is really nothing anyone can do about their death wish? _____.

14. List four psychosocial symptoms of a potential suicide victim.

    a. _____.

    b. _____.

    c. _____.

    d. _____.

15. Do not leave an individual with suspected suicidal intentions alone at any time because _____.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 2

1. A state of physical and emotional exhaustion in which one feels a negative self-concept and negative attitude toward his job. (para 2-2a)

2. You are correct if you listed any four of the following:

   Overwork.
   Shortage of staff and supplies.
   Unresponsive leadership.
   Lack of group cohesiveness.
   Lack of recognition for a job well done.
   Lack of resources.
   Lack of rewards.
   Short-fused suspenses. (para 2-2b)

3. Family separations.
   Frequent moves.
   Feeling of isolation from society in general.
   Frequent change in staff. (para 2-2b(9))

4. You are correct if you listed any three of the following:

   Fear of death or injury.
   Lack of preparation or training.
   Fear of failure or losing face in combat.
   Lack of adequate rest and/or nutrition.
   Lack of adequate sanitation.
   Feelings of facing overwhelming odds.
   Long periods of a very high stress situation without relief. (para 2-2d)

5. You are correct if you listed any four of the following:

   Physical and mental exhaustion.
   Less production/enjoyment at work.
   Disenchanted with work and life.
   Unexplained depressions.
   Irritable and short tempered.
   Impotent or lack of sexual desire.
   Less contact with coworkers.
   Decreased social interaction with family and friends. (para 2-2e)

6. Home. (para 2-2e(9))

7. Despair.
   Hopelessness. (para 2-3a)

8. You are correct if you listed any three of the following:

   Trouble with concentration/memory.
   Feelings of guilt about inconsequential events.
   Insomnia or excessive sleepiness.
   Feelings of hopelessness and worthlessness.
   Withdrawal from activities and interests.
   Decreased interactions with family and friends.
   Decreased work productivity.
   Decreased relationship with coworkers.
   Changes in bowel habits.
   Weight loss or gain.
   Decreased sexual drive.
   Slowed speech and/or motor activity. (para 2-3c)

9. Antidepressant.
   Antipsychotic. (para 2-3d)

10. Voluntarily.
    Intentionally. (para 2-4d(7))

11. You are correct if you listed any three of the following:

    Ending or/trouble with a close personal relationship.
    Death of a loved one.
    Worry related to job.
    Move to a new place.
    Health problems.
    Complications with excessive use of drugs or alcohol. (para 2-4e)

12. Myth. People who talk about suicide do usually attempt suicide. (para 2-4f(1))

13. Myth. In fact, people who are suicidal are often undecided about whether to live or die. Suicide may be a call for help. (para 2-4f(3))

14. You are correct if you listed any four of the following:

    Depressed mood.
    Change in appearance.
    Change in work habits.
    Changes in usual patterns of behavior.
    Marital and family problems.
    Financial problems.
    Interpersonal problems. (para 2-4i(1) thru (7))

15. He might kill himself. (para 2-4k(2))

End of Lesson 2

LESSON ASSIGNMENT

LESSON 3	Hostility and Violent Behavior.
LESSON ASSIGNMENT	Paragraphs 3-1 through 3-7.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

3-1. Identify the most common precipitating factors in violent behavior.

3-2. Identify the methods used to manage the violent patient who is unarmed.

3-3. Identify the methods used to manage the violent patient who is armed.

3-4. Identify the uses of restraints for violent patients.

SUGGESTION After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 3

HOSTILITY AND VIOLENT BEHAVIOR

3-1. INTRODUCTION

As a medical NCO, you may encounter situations in which you need to react promptly. For example, suppose you are assigned to provide medical coverage at the rifle range. A soldier begins arguing with his scorer on the number of targets he hit. He suddenly points his weapon in the direction of the other soldiers and begins shouting obscenities. What do you do? How would you react? These questions and more will be answered in this lesson.

3-2. VIOLENT BEHAVIOR

a. **Definition.** The patient exhibiting violent behavior is the individual whose behavior is potentially hazardous to himself or to others. The fear associated with many psychiatric patients is caused from their actions of violence or destruction. The actual number of such patients is greatly exaggerated. Violent behavior is not peculiar to any type of diagnosis.

b. **Causes.** There are several precipitating factors to violent behavior. Included are the following:

(1) Medical illness for which organic brain syndrome is the common cause.

(2) Personality disorders such as poor impulse control.

(3) True neuropsychiatric illnesses (the person experiences delusions of persecution and "hearing voices").

3-3. MANAGEMENT OF AN UNARMED VIOLENT PATIENT

The violent, agitated patient must be controlled before attempts are made to diagnose or to refer the patient for help.

a. **Verbal Control.** Verbal control should be the first attempt made. As you approach the patient, talk calmly to him. Avoid threatening him. Tell him who you are, where and how you plan to help him; this is called reorienting information. Ask him questions about what is troubling him. Try to find the cause of his agitation. Asking why he is upset often stimulates the patient to think rationally. Additionally, these questions provide necessary information. Often, the verbal approach is enough to calm someone who is not in a panic, anxiety state. The verbal approach is usually effective with patients who are psychotic (person who has lost contact with reality).

b. **Medial Care Image.** If verbal control is successful (the violent patient has calmed down), continue to reassure the patient and provide orienting information. Reinforce the "medical care image." For example, the patient on the rifle range in the first paragraph of this lesson could be told, "Good. You are looking calmer. I should check your pulse and blood pressure now." If the patient accepts this, he is agreeing to sit still and talk while you prepare for the next step.

c. **Restrain the Patient.** If you cannot control the patient verbally, he must be brought to a horizontal position on the floor or ground to ensure his safety and the safety of any other people in the area. To do this, you should have a minimum of four to five people. If you do not have this number of people to help, wait until you do have the number unless the patient is so dangerous that something must be done at once. When you have decided to take action, do so quickly and decisively. When the patient is on the floor, place a stretcher under him. Use sheets or cuff restraints to maintain secure control. If necessary, give medication to help the patient maintain his own control. It is best to give no medication until the cause of the violent behavior can be determined because some drugs interact badly with some illnesses. If you must administer medication, a careful follow-up is necessary. Convey the attitude that you believe the patient is a decent human being who is struggling to control difficult thoughts and feelings. Assure the patient that no harm will come to him nor will he be allowed to harm anyone. An expeditious transfer should be arranged for the patient to a medical treatment facility for evaluation.

3-4. MANAGEMENT OF THE ARMED, VIOLENT PATIENT

An armed, violent patient can be managed if certain measures are taken. Follow these procedures:

a. Leave the area quickly, if possible.

b. Warn all personnel to clear the area and notify the authorities.

c. If you are unable to leave, keep talking and allow no long silences to develop. Try saying things such as, "You can do a lot of harm if you want to, even without a gun." or "You look frightened, and I feel frightened." You can also say, "I'd like to help you, but I'm concerned that you might do something with that gun you can't take back. Could you please put it down, or let me hold it for you until we can finish talking about what is troubling you?" Make no abrupt movements. If the subject will not give up his weapon, he may at least be willing to put it into his pocket or into a nearby desk drawer. It is important to offer him free access to the exit. This could be achieved by asking if he would feel better leaving the room or staying. Stand away from doors to keep the patient from feeling trapped and cornered. The patient's behavior may depend on your position and your reaction. If the patient leaves the room, alert all personnel and the police.

NOTE: After an encounter with a violent patient (armed or unarmed), meet with the staff and tell them what was done and why. Give the staff the opportunity to express their feelings.

3-5. USE OF RESTRAINTS

a. **When to Use Restraints.** Restraints are used in the following situations:

(1) The patient is violent.

(2) The patient refuses to go to a medical or psychiatric facility for evaluation.

(3) The patient is hallucinating or has delusions.

(4) The patient is evacuated by air.

(5) The patient is having a substance abuse reaction such as severe alcohol withdrawal or barbiturate withdrawal.

b. **How to Use Restraints.** There are standard restraining devices and field expedient restraints. Standard restraining devices can be found in a hospital or clinic. Field expedient restraints include material commonly carried by a soldier in the field such as rifle slings, web belts, bandoleers, and cravats. If used, field restraining devices should be replaced with standard restraining devices as soon as possible. Field restraining devices should not be used on a patient over long periods of time because such devices may rub on the patient's skin causing him injury.

c. **Field Restraining Device--the Double Litter.** Follow these steps to use the double litter with litter straps as restraints:

(1) Place the patient on the litter in the prone position with his head turned to one side to help prevent aspiration pneumonia.

(2) Put each of the patient's hands along his thigh and secure each hand to the litter.

(3) Place the other litter, the carrying side down, on top of the patient.

(4) Bind the litters together with two or more litter straps.

(5) Record and report the action taken on DA form SF 600. Include the date and time the restraints were applied, the type of restraints applied, and the patient's tolerance of the procedure.

d. **Hazards of Restraints.** Included are the following:

(1) Damage to body tissue.

(2) Damage to other parts of the body.

(3) Development of pressure areas if the patient is restrained for long periods of time or if the patient does not have frequent position changes.

(4) Damage to nerves if the restraints are applied too tightly or if the restraints become too constrictive after application.

(5) Injury or death due to use of restraints during a fire or other occurrence.

3-6. AIR EVACUATION OF PSYCHIATRIC PATIENTS

The FORSCOM message below describes how the U.S. Army's psychiatric patients should be evacuated by air.

> FORSCOM message: August 1978, Air Evacuation of Psychiatric Patients by Helicopter. Air evacuation for psychiatric patients is not as critical an adjunct to therapy as it is for the physically ill or injured patient and they (the psychiatric patient) may react unpredictably to the air travel especially under adverse operational conditions. Therefore, Army air ambulances should not be routinely used to transport psychiatric patients merely as an expedient. Before a diagnosed psychiatric patient may be accepted for air transportation by an air ambulance crew, the senior medical officer must certify that two situations exist: (1) air transportation is medically essential, and (2) the patient is appropriately sedated and restrained to prevent him from becoming a hazard to the aircraft and crew.

3-7. CLOSING

This lesson has addressed the major areas of consideration for the management of patients with hostile and violent behavior. Your ability to deal effectively with a violent or hostile individual can be of utmost importance. Whether in the field or in a hospital environment, the knowledge and expertise used in handling this type of situation can be invaluable to the patient, other personnel, and to you.

Continue with Exercises

EXERCISES, LESSON 3

INSTRUCTIONS. The following exercises are to be answered by completing the incomplete statement or by writing the answer in the space provided. After you have completed all the exercises, turn to the solutions located at the end of the exercises and check your answers.

1. A patient exhibiting violent behavior is potentially hazardous to _____

   _____

2. List three factors which could cause violent behavior in a person.

   a. _____.

   b. _____.

   c. _____.

3. What is the first action to take when confronted with an armed, violent patient who will not let you leave the area? _____

   _____

4. What is the first action to take when you are dealing with an unarmed, violent patient? _____.

5. List three items which could be used as field expedient restraints.

   a. _____.

   b. _____.

   c. _____.

6. List three hazards of using restraints.

   a. _____.

   b. _____.

   c. _____.

7. List the two situations which must exist for a psychiatric patient to be evacuated by air.

   a. _____.

   b. _____.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 3

1. Himself or others. (para 3-2a)

2. Medical illness for which organic brain syndrome is the common cause.
   Personality disorders such as poor impulse control.
   True neuropsychiatric illnesses. (para 3-2b)

3. Keep talking to the patient, allowing no long silences to develop. (para 3-4c)

4. Try talking calmly to the patient (verbal control). (para 3-3a)

5. Cravats.
   Web belts.
   Rifle slings. (para 3-5b)

6. You are correct if you listed any three of the following:

   Damage to body tissue.
   Damage to other parts of the body.
   Development of pressure areas.
   Damage to nerves.
   Injury or death due to restraints during a fire or other occurrence.
   (para 3-5d)

7. Air transportation must be medically essential.
   Patient must be appropriately sedated and restrained. (para 3-6)

End of Lesson 3

LESSON ASSIGNMENT

LESSON 4	Substance Abuse.
LESSON ASSIGNMENT	Paragraphs 4-1 through 4-10.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

4-1. Identify the signs/symptoms and treatment for overdose and withdrawal of opioids.

4-2. Give examples, identify signs/symptoms and treatment for overdose and withdrawal of central nervous system depressants.

4-3. Identify examples, signs/symptoms and treatment for overdose and withdrawal of central nervous system stimulants.

4-4. Identify signs/symptoms and treatment of cannabinoids.

4-5. Identify examples, signs/symptoms, and treatment for overdose and withdrawal of psychedelics.

4-6. Identify signs/symptoms and treatment for overdose of phencyclidine.

SUGGESTION After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 4

SUBSTANCE ABUSE

4-1. INTRODUCTION

Substance abuse, whether it involves alcohol or cocaine, has become a major health problem in society today. Substance abuse, more commonly called drug abuse, has tragic consequences; for example, the extremely high rates of alcoholism and the cases of cocaine abuse among star athletes and entertainers. In the 1950s, drug or substance abuse referred mainly to heroin abuse, and the people doing the abusing lived mostly in the run down areas of large cities. Today, millions of people in the United States are drug abusers, and they come from all parts of American society and include people from all age groups.

a. **Historical View.** Use of drugs is not new in the history of civilization. For centuries, people have used a variety of spirits, herbs, and potions to relieve feelings of sadness, loneliness, tension, and boredom. Opium, for example, has been used for about 5000 years. From 130 to 201 A.D., opium was thought to resist poison and snake bites, cure headache, vertigo, deafness, epilepsy, asthma, spitting of blood, fevers, leprosies, and a variety of other maladies. As long as the drugs were used moderately, society seemed to have accepted their use. When drugs have been taken excessively, society has declared substance or drug use illegal and labeled the users as criminals.

b. **Definition of Substance or Drug Abuse.** The definition is as follows: excessive taking of a substance (such as alcohol) or a drug (usually self-administered) that produces effects on the person's moods, thoughts, and feelings; substances taken without the advice or direction of a doctor and not for treatment of a disease or health problem; a drug whose effects could lead to antisocial behavior. The term substance abuse and drug abuse will be used to mean the same thing throughout this lesson.

c. **Substance or Drug Effects.** How a substance or drug affects each person depends on several elements: the amount taken at one time; the past drug experience of the user; the circumstances in which the drug is taken (the place, the feelings and the activities of the user, the presence of other people, the use of alcohol or other drugs at the same time, etc.); and the manner in which the drug is taken (inhaled, smoked, injected, ingested). Short-term effects refer to those signs and symptoms that appear after a single dose and disappear within a few hours or days. An example of a short-term effect is the high experienced by a user after a small dose of marijuana. Long-term effects are the signs and symptoms which appear following repeated use of the substance or drug over a long period of time. For example, chronic, heavy users of substances in the cannabis classification may show loss of energy and drive, slow and confused thinking, impaired memory, and apathy. They may also suffer from bronchitis and other respiratory diseases.

d. **Additional Terms.**

(1) Psychological dependence. This means that the drug has become so central to the person's thoughts, emotions, and activities that he needs to continue using amounts of the drug to satisfy a craving or compulsion for it. This dependence is a mental or emotional adaptation to the effects of the drug. The abuser likes the way the drug makes him feel, wants to re-experience those feelings, and actually believes that he cannot function without the drug. The drug helps the abuser escape from reality--from his problems and frustrations. The drug and its effects seem to provide the answer to everything, including disenchantment and boredom. As long as he takes the drug, all seems well. It is this psychological dependence which causes an abuser who has been withdrawn from his physical dependence to return to drug abuse.

(2) Physical dependence. The body has adapted so thoroughly to the presence of the drug that the user experiences withdrawal signs and symptoms if he stops using the drug suddenly. With repeated use, many drugs cause physical dependence. The body learns not only to live with the drug but also to tolerate and require ever increasing doses of the drug. Withdrawal signs and symptoms vary with the amount and kind of drug the abuser has used. Once the person's body adjusts to being without the drug, withdrawal symptoms often disappear. In some cases, there are permanent effects caused by the drug, and these effects do not disappear.

(3) Tolerance. This term refers to the fact that a person who uses some drugs regularly finds that he must constantly increase the dose in order to get an effect equal to that he experienced from the first dose. The body has adapted to the presence of a foreign substance--the drug--and now requires more of the foreign substance for unique feelings. Tolerance does not develop for all drugs or in all people, but those who use drugs such as morphine find that tolerance builds up very quickly.

NOTE: Tolerance does not develop for all the possible effects of a particular drug. For example, tolerance develops for the euphoric-like effects (feeling of well-being) of heroin but only slightly to the constricting effects on the pupil of the eye. Complete tolerance to a drug's toxic (poisonous) effects may not develop in a person. This makes it possible for a drug abuser to give himself a fatal dose of the drug.

(4) Behavior changes. All substances which can be abused can cause changes in a person's behavior, particularly when large amounts of the substance are improperly used. After taking the substance or drug, the person may become withdrawn and solitary or sociable and talkative. On the other hand, he may be easily moved to tears or laughter. He may become very argumentative and believe that someone is out to get him. Such changes in behavior may be harmless or a danger both to the user and society. Much of the public concern about drug abuse comes from the wide publicity given to changes in behavior that may accompany the use of drugs; for example, LSD which has been particularly responsible for bizarre behavior.

(5) Addiction and habituation. These two terms have frequently been confused. Addiction has been defined as a state of periodic or chronic intoxication produced by repeated consumption of a drug and involves tolerance, psychological dependence, usually physical dependence, and an overwhelming compulsion to continue using the drug. Addiction is detrimental to both the individual and society. Habituation has been defined as a condition which results from repeatedly using the drug. There is no evidence of tolerance, a little psychological dependence, no physical dependence, and a desire (but not a compulsion) to continue taking the drug because it makes the person feel good. The individual's health may get worse. The drug addict is unable to stop without getting professional help and also without experiencing withdrawal signs and symptoms. On the other hand, the person with a drug habit should be able to stop using the drug if he can just find another way of feeling good.

4-2. OPIOIDS (NARCOTICS)

a. **Definition/Examples.** The term opioid describes any natural or synthetic drug that has morphine-like actions. Such drugs are also referred to as narcotic analgesics (narcotic pain-killers). The principal medical use of such drugs is for the relief of pain. Opioids can be grouped in three classifications: natural substances (opium, morphine, and codeine); semisynthetic drugs (drugs produced through minor chemical alterations of the basic poppy product (heroin is an example)); and synthetic analgesics (meperidine and propoxyphene). Opium, morphine, heroin, methadone, and meperidine (Demerol®) are all examples of opioids.

b. **Opioid (Narcotic) Abuse.** The appeal of morphine-like drugs lies in their ability to reduce the person's sensitivity to psychological and physical stimuli and to give the person a sense of well-being. These drugs dull fear, tension, or anxiety. Under the influence of morphine-like opioids, the user is usually lethargic and indifferent to his environment and personal situation. For example, a pregnant addict will usually continue drug abuse despite the fact that her baby will be born addicted and probably die shortly after birth unless medical treatment is undertaken at once. Her indifference to her personal situation--the pregnancy--is so great that she does not care enough to stop taking drugs even though the drugs are hazardous to her health and the health of her unborn child.

c. **Results of Chronic Opioid (Narcotic) Use.** The price tag on the abuse of opioids is high. Chronic use may lead to both physical and psychological dependence. Psychological dependence is the more serious of the two because the user can still be psychologically dependent on the drug even after he stops using the drug. The person who uses the drug chronically develops tolerance and finds he needs ever-increasing doses to get the desired feelings. As the need for the drug increases, the user's activities become more drug-centered. When drug supplies are cut off, the user suffers withdrawal symptoms.

d. **Signs/Symptoms of Opioid (Narcotic) Abuse.** Opioids are substances which combine the actions of an analgesic (a pain killer), a hypnotic (sleep producer), and a euphoriant (good-feeling producer). The various signs and symptoms experienced by someone who has taken opioids (narcotics) are related to these three characteristics.

(1) Intoxication/overdose signs and symptoms. Included are:

(a) Decreased urine output. Opioids stimulate an antidiuretic hormone causing the body to put out less urine.

(b) Pinpoint nonreactive pupils. Opioids cause the pupils of the eye to constrict (get smaller).

(c) Constipation. Motility (spontaneous movement) of the gastrointestinal system is decreased by opioids.

(d) Sex hormone levels depressed. Those who use morphine and morphine derivatives have a lower sex drive. Menstrual cycles in heroin addicts change.

(e) Wheals or hives at an injection site/generalized itching/decreased blood pressure. All of these are the result of the body releasing more histamines.

(f) Suppression of the cough reflex/drowsiness/respiratory depression/coma. All of these are caused by the opioids' generalized depression of the body's central nervous system. Respiratory arrest is possible. Coma occurs if the dosage of the drug is high.

(g) Subnormal temperature.

(h) Hypoventilation (diminished ventilations).

(2) Withdrawal signs and symptoms. The nature of withdrawal and the severity of the symptoms depend on the particular opioid (narcotic) involved, the total daily dose, how long the opioid has been used, and the health and personality structure of the user. Generally, the shorter the drug effects last, then the shorter and more intense is the withdrawal time. Withdrawal symptoms for opioids begin from 3 to 48 hours after the last opioid used. Meperidine (Demerol®) withdrawal begins about three hours after the last dose. Morphine/heroin withdrawal begins about eight hours after the last dose, and methadone withdrawal begins about 24 hours after the last dose. When a person addicted to opioids (narcotics) does not get a dose of the drug within roughly eight hours, the individual begins to experience withdrawal symptoms. For some users, withdrawal is not dangerous or even very painful, and some users withdraw without outside help. In other cases, however, user withdrawal is both painful and dangerous. Withdrawal signs and symptoms include the following:

(a) Lacrimation (excessive secretion of tears).

(b) Rhinorrhea (profuse, watery nasal discharge).

(c) Sweating.

(d) Nausea and vomiting.

(e) Elevated pulse and blood pressure.

(f) Intestinal spasms.

(g) Diarrhea.

(h) "Goose flesh."

(i) Hyperventilation.

(j) pH imbalances.

(k) Dehydration. This is a concern because sweating, vomiting, and diarrhea all contribute to loss of body fluids. Excessive loss of body fluids can keep body parts from functioning properly and eventually be fatal.

NOTE: The individual addicted to opioids (narcotics) finds his life more and more centered around getting and using drugs so that the addiction usually leads to lying, stealing, and association with those who can supply the drug. Even after the user goes through withdrawal, biochemical changes in his body seem to force him to continue to crave the drug.

e. **Treatment for Opioid (Narcotic) Abuse.**

(1) Treatment for opioid overdose. Follow these procedures:

(a) Maintain the airway.

(b) Administer oxygen.

(c) Initiate an IV with D5W.

(d) Administer Naloxone NARCAN IV 0.4 mg (1 ml).

(e) Monitor the patient's cardiac rhythm.

(2) Treatment for withdrawal from opioids (narcotics). Follow these procedures:

(a) Maintain the patient's airway.

(b) Initiate an IV with D5W.

(c) Administer barbiturates.

(d) Administer phenothizaines PO such as Compazine®, Phenergan®, or Vistaril®. Phenothiazines are administered to prevent nausea and vomiting.

(e) Monitor the patient's cardiac rhythm.

4-3. GENERAL CENTRAL NERVOUS SYSTEM (CNS) DEPRESSANTS

a. **Definition/Examples.** A wide variety of drugs with different physical and chemical properties are included in this category. They are grouped together because they all cause a generalized depression of the central nervous system. Alcohol, barbiturates, and sedatives are examples of this classification of drugs.

b. **Alcohol.** Alcohol is a drug that can become addictive. It is one of the most widely used CNS depressants. Alcohol can be produced synthetically or naturally by fermenting fruit, grain, or vegetables. Alcohol is usually consumed in the United States in the form of beer, liquor, or wine.

(1) Alcohol abuse. Alcohol acts as a depressant on the central nervous system (slows it down) when it (alcohol) is absorbed into the bloodstream. After absorption into the bloodstream, alcohol is distributed uniformly to all body fluids. Alcohol enters the brain easily and crosses the placental barrier into the fetus in pregnant women. How fast alcohol is absorbed into the bloodstream and the body fluids depends on the kind of drink (beer or sweet wine is absorbed more slowly than dry wine or distilled spirits) and on the contents of the stomach. How quickly alcohol is absorbed and how rapidly it affects the user also depend on whether the stomach is empty or full. A full stomach slows down both the rate of absorption and rapidity of effects on the drinker. The effects of alcohol also depend on the amount of alcohol consumed, the circumstances of consumption (setting), on the body size, and on the experience of the drinker.

(2) Intensity of alcohol effects. A person who is not used to consuming alcohol will usually show signs of drinking sooner than someone who is used to drinking. The conditioned drinker has learned how to adjust his behavior to the changes alcohol makes in his behavior. Physical reactions to alcohol range from the person becoming more talkative, appearing slightly flushed, and becoming somewhat uninhibited in his actions to the individual who staggers, has blurred vision, and shows obvious signs of drunkenness. Alcohol consumption causes some people to become emotional or amorous while other people become aggressive and hostile.

(3) General effects of alcohol. Very high doses of alcohol can cause a person to pass out. If the central nervous system is slowed down enough, the person may die. In moderate doses, alcohol usually reduces a person's ability to perform tasks that require physical coordination or mental agility such as driving a car or performing a desk job well. Driving a car while under the influence of alcohol is particularly dangerous.

(4) Long term effects of alcohol.

(a) Physical dependence. An individual can become physically dependent on alcohol after a few weeks of heavy drinking or over a period of several years of gradually increased drinking. Physical dependence is the point at which withdrawal symptoms are experienced if the drinking stops. Signs and symptoms of typical withdrawal for the physically dependent person include appetite loss, nausea, anxiety, sleeplessness, severe agitation and irritability, confusion, tremors, vomiting, illusions, and hallucinations. Signs and symptoms of cases of severe withdrawal include delirium tremors, convulsions, exhaustion, and, perhaps, cardiovascular collapse.

(b) Psychological dependence. A person who finds himself drinking in order to deal with the stresses and strains of daily living has become psychologically dependent on alcohol. The early signs of this drinking pattern include drinking to relieve boredom or depression; drinking to escape unpleasant emotional reactions or situations; or drinking to relax just before going to new social situations.

(5) Related illness. Alcohol has been related to a wide range of illnesses. Note these facts:

(a) An alcoholic has twice the chance of premature death than a nonalcoholic person. Several forms of liver disease are associated with alcoholism. Cirrhosis of the liver is the third fastest growing cause of death among males 20 to 40 years of age. Alcoholics have higher than normal rates of peptic ulcers, suicide, pneumonia, cancer of the upper digestive and respiratory tracts, and tuberculosis. Characteristic of many heavy drinkers are vitamin deficiency, gastritis, sexual impotence, and infections. Alcohol- related neurological disorders include loss of sensation, loss of memory, and mental confusion.

(b) Other neuropsychiatric conditions associated with alcohol consumption include alcoholic hallucinations, delirium tremens (acute mental disturbances marked by pain, sweating, tremors, and visual and auditory hallucinations), and various convulsive disorders.

(6) Early warning signs of alcoholism. A drinking problem usually develops over a period of time. There are almost always warning signals. An individual may be on the way to alcoholism if he:

(a) Is difficult to get along with when he is drinking.

(b) Drinks because he is depressed.

(c) Drinks until he is "dead drunk" at times.

(d) Drinks to calm his nerves.

(e) Can't recall some drinking episodes.

(f) Hides liquor.

(g) Lies about his drinking.

(h) Neglects to eat when he is drinking.

(i) Neglects his family when he is drinking.

(7) Treatment. If you come in contact with a person who is an alcohol abuser, refer him to your local drug abuse counselor. If no such person exists in your area, notify the officer in charge.

c. **Barbiturates.** Barbiturates are powerful sedatives which were introduced in the 1930s. These drugs have legitimate medicinal uses. They are prescribed by doctors to calm patients and/or induce sleep. Their action, like alcohol, is to slow down the central nervous system. Properly used, the drug makes the patient feel relaxed, drowsy, and sleepy. If taken incorrectly, barbiturates can result in physiological and psychological dependence and even death. Examples of barbiturates include phenobarbital, secobarbital, and pentobarbital. Users of barbiturates can easily take a fatal overdose, either intentionally or accidentally, because excessive use leads to deterioration of a person's problem-solving ability. Additionally, increased use of barbiturates does not lead to increased tolerance of barbiturates. Because a user is not thinking clearly and because there is no way to build up a tolerance for barbiturates, he may take too much or the right amount too soon with tragic results.

d. **Sedatives.** Included in this category are drugs which relieve anxiety, tension, and muscle spasms, produce sedation, and prevent convulsions. These drugs are marketed as minor tranquilizers, sedatives, hypnotics (sleep inducing), or anticonvulsants (prevent convulsions). These drugs are safer than other central nervous depressants, but users can become physically and psychologically dependent with long use. Long use of sedatives can also result in the user experiencing withdrawal symptoms. Examples of sedatives include diazepam (Valium®) and chlordiazepoxide (Librium®).

e. **Signs/Symptoms of Central Nervous System Depressant Abuse.**

(1) Overdose. Characteristics of central nervous system depressant overdose include:

(a) Constricted pupils (initially).

(b) Fixed and dilated pupils of the eye (late stages).

(c) Respirations, slow or shallow.

(d) Respiratory acidosis (increase in hydrogen ion in the body fluids caused by failure of respiratory system to eliminate carbon dioxide effectively).

(e) Hypotension (abnormally low blood pressure).

(f) Cyanosis (bluish discoloration of the skin, lips, and nail beds as a result of insufficient oxygen in the blood).

(g) Shock syndrome.

(h) Coma.

(i) Respiratory arrest.

(2) Withdrawal. Signs and symptoms of withdrawal may begin from six to 24 hours after the last dose of a central nervous system depressant. Included are the following;

(a) Anxiety or weakness.

(b) Abdominal cramps.

(c) Nausea or vomiting.

(d) Orthostatic hypotension (abnormally low blood pressure occurring when an individual gets up suddenly from a recumbent (lying down, leaning, reclining) position). The blood drops rapidly when the person stands up; consequently, fainting is a common symptom of this type of hypotension.

(e) Visual hallucinations (sees things that aren't there).

(f) Seizures.

(g) Delirium.

(h) Hyperthermia (very high body temperature).

(i) Cardiovascular collapse.

f. **Treatment for Central Nervous System Depressant Abuse.**

(1) Overdose. Follow this procedure:

(a) Maintain the patient's airway.

(b) Administer oxygen.

(c) Initiate an IV with normal saline solution.

(d) Administer sodium bicarbonate IV (on doctor's orders) to correct the pH balance and alkalinize the urine.

(e) Do NOT give the patient stimulants.

(2) Withdrawal. Follow these steps:

(a) Initiate an IV with normal saline solution.

(b) Administer supportive measures, as necessary.

(c) Hospitalize the patient.

4-4. CENTRAL NERVOUS SYSTEM (CNS) STIMULANTS

a. **Definition/Examples.** For thousands of years, people have used stimulants. The most common stimulants are the nicotine in tobacco products and the caffeine in coffee, tea, and some cola beverages. Central nervous system depressants such as those in paragraph 4-3 of this lesson slow down the action of the body's central nervous system while central nervous system stimulants speed up the body's system. Examples of central nervous system stimulants include cocaine and amphetamines. Common amphetamines include Dexedrine®, Benzedrine®, and Methedrine®.

b. **Signs/Symptoms of Central Nervous System Stimulant Abuse.**

(1) Intoxication/overdose. Included are the following:

(a) Excitement.

(b) Paranoia.

(c) Tachycardia.

(d) Hypertension.

(e) Sweating.

(f) Dilated pupils.

(g) Hallucinations.

(h) Cardiac arrhythmias.

(i) Convulsions.

(j) Respiratory collapse.

(2) Withdrawal. Included are the following:

(a) Apathy.

(b) Psychomotor depression.

(c) Sleep disturbance.

(d) Suicidal tendencies.

c. **Treatment for Central Nervous System Stimulant Abuse.**

(1) Overdose. Follow this procedure:

(a) Initiate IV of normal saline solution.

(b) Administer diazepam (Valium®) IV for convulsions.

(c) Acidify urine with ammonium chloride.

(d) Administer chlorpromazine (Thorazine®) for hypertension.

(2) Withdrawal. Follow these steps:

(a) Observe the patient in a controlled environment.

(b) Acidify urine to expedite urination.

4-5. CANNABINOIDS

a. **Definition/Examples.** Drugs in the cannabinoid class are obtained from a hemp plant, a plant which grows throughout most of the tropic and temperate zones of the world. The principal products of this plant are marijuana and hashish. Cannabis (marijuana) is a substance obtained from the flowering tops, leaves, and stems of the hemp plant. More than 400 compounds from the plant resin have been isolated and identified from Cannabis sativa or Cannabis indica, the hemp plants from which marijuana and hashish are produced. Marijuana is made up of the cut and dried stems, leaves, and tops of the hemp plant. Hashish is composed of the resinous secretions of the hemp plant, secretions which are collected, dried, and compressed into balls, cakes, or cookie-like sheets. Liquid from the hemp plant is processed to make hashish oil.

b. **Signs/Symptoms of Cannabinoid Abuse.** Included are the following:

(1) Psychomotor impairment.

(2) Dilated pupils.

(3) Tachycardia.

(4) Paranoia.

c. **Treatment for Cannabinoid Abuse.** Give treatment for the symptoms that the patient has. True addiction does not occur.

4-6. PSYCHEDELICS (HALLUCINOGENS)

a. **Definition/Examples.** Drugs in this class change the user's view of the world from real to something else, perhaps fantasy. When these drugs are taken in large doses, they produce a variety of effects that users call the psychedelic experience." Examples of psychedelics include LSD (lysergic acid diethylamide), psilocybin, mescaline, and peyote.

b. **Signs/Symptoms of Psychedelic Abuse.**

(1) General signs and symptoms. Included are the following:

(a) Dilated pupils.

(b) Hallucinations (usually visual).

(c) Unusual body sensations.

(d) Panic.

(2) LSD signs and symptoms. In general, the LSD experience consists of changes in perception, thought, mood, and activity.

(a) Perceptual changes. LSD changes the user's senses of sight, hearing, touch, body image, and time. Colors seem to intensify or change shape, and relations appear distorted. Objects seem to pulsate. Two dimensional objects appear to become three dimensional, and inanimate objects seem to assume emotional importance. The user becomes more sensitive to sound but cannot find the source of the sound. He can hear but not understand conversations. Sometimes he also hears music and voices that are not there. Food may feel gritty, and its taste may be different. He touches cloth which feels either coarse and dry or fine and velvety. The user may feel cold or sweaty. He has sensations of lightheadedness, emptiness, shaking, vibrations, and fogginess. He may hold his arms or legs in one position for long periods of time. Time seems to him to race, stop, slow down, or even go backwards. The user has a stream of bizarre, free-flowing thoughts including the idea that someone is out to get him. Little unimportant events become very significant and important.

(b) Mood effects. The LSD user may experience a wide variety of moods. He may burst into tears, laughter, or feel no emotion at all. Regardless of his emotional state on the outside, the user may actually feel completely relaxed and happy. On the other hand, an LSD user could feel anxiety, fear, and panic because (for no apparent reason) he feels alone and cut off from the world. For this reason, some LSD users make sure that a friend who is not using LSD will be there to prevent suicidal attempts or dangerous reactions to the panic.

(c) Diminishing LSD effects. After a number of hours, the effects of LSD begin to wear off. Waves of the LSD experience, diminishing in intensity, alternate with periods when the user feels no effects at all. Finally, all symptoms of LSD use disappear. Long after the person has used the drug, he may experience tiredness, tension, and recurrent hallucinations. The user may experience psychological changes which last for an indefinite period of time. For example, those with neuroses or character disorders will find their condition worsened after using LSD.

NOTE: LSD users report that the hallucinogenic flashbacks (recurrence of seeing and/or hearing things that are not there) were very unpleasant experiences.

(d) Warning--LSD. Some individuals claim to have used LSD without ill effect; however there is growing medical evidence that LSD can cause very serious and often damaging reactions in many people. Bizarre behavior in public, panic, fear, and homicidal and suicidal urges have been reported. Psychotic states have been induced in both emotionally stable and emotionally unstable individuals who have used LSD. LSD can produce delayed psychotic reactions in some individuals. As mentioned previously, hallucinations have happened weeks after the person took the drug. Additionally, there is evidence that LSD can cause genetic damage. In the opinion of Dr. James L. Goddard, former Commissioner of Food and Drugs, medically unsupervised use of LSD is like playing "chemical Russian roulette."

(3) Psilocybin signs and symptoms. This drug is not as potent as LSD, but the psilocybin user can experience hallucinations similar to those experienced with LSD. Psilocybin has been used in Indian religious rites as far back as pre-Columbian times.

c. **Treatment for Psychedelic Abuse.** Psychedelics are not usually used over long periods of time. Instead, these drugs are generally taken to provide an occasional "trip," highs of thoughts and feelings that are not (or cannot be) experienced otherwise except in dreams or at times of religious jubilation. In the event that treatment is needed, try to talk the user back to reality (the talkdown approach). If necessary, administer diazepam (Valium®) should the person be in severe panic.

4-7. PHENCYCLIDINE (PCP)

a. **Definition/Examples.** Drugs in this class have these properties: depressant (slows functions of the body); stimulant (makes bodily functions go faster); hallucinogenic (seeing things that aren't there or believing events happened which didn't happen); and analgesic properties (pain killing). The best known drug of this class is phencyclidine (PCP). This drug can't properly be classified as a hallucinogen, a stimulant, or a depressant. Originally, it was sold to veterinarians to be used as anesthesia on large animals. There are at least 200 street names for PCP including "angel dust," "THC," "Tic," "dust," and "super weed." PCP is a white crystalline powder which dissolves in water. It can be smoked, ingested, or injected. Originally, PCP was developed as a sedative, general anesthetic, and analgesic. It worked very well in

clinical testing, but it was found to have unfortunate aftereffects. Patients coming out of the anesthetic state experienced symptoms ranging from mild to great disorientation, agitation, manic excitation, delirium, and hallucinations. As a result, testing of PCP on humans was discontinued. Today, almost all PCP is made and used illegally.

b. **Signs/Symptoms of Phencyclidine Abuse.** Included are the following:

(1) Sweating.

(2) Catatonic muscular rigidity.

(3) Amnesia.

(4) Tachycardia (abnormally fast heartbeat).

(5) Hypertension (high blood pressure).

(6) Hypersalivation (excessive secretion of saliva).

(7) Fever.

(8) Convulsions.

(9) Coma.

c. **Treatment for Phencyclidine Abuse.** Included are the following:

(1) Protect the patient. Keep him from hurting himself.

(2) Support the patient's vital signs.

(3) Acidify the patient's urine.

(4) Use suction to remove the excess saliva in the patient's mouth.

(5) Administer diazepam (Valium®) for convulsions.

(6) Schedule a psychiatric follow-up.

4-8. INHALANTS

a. **Definition/Examples.** Inhalants are mood-changing substances which can enter the body when the user breathes in substance fumes. Most inhalants are gases at room temperature or turn into gas when exposed to air. These substances quickly intoxicate (temporarily lessen a person's control over his physical and mental powers). The user breathes the gaseous substance into his lungs. Since the lungs have a large

surface area, the gaseous substance is quickly absorbed into the bloodstream causing the user to feel the substance's effects very soon. The list of substances commonly inhaled changes constantly. Each generation seems to add new substances and delete some of the old ones. Inhalants of the 1960s were chiefly plastic model glue, nail polish removers, and aerosol sprays. Today, some of the most commonly inhaled substances are paint thinners, paint removers, lighter fluids, dry cleaning fluids, kerosene and other petroleum products, anesthetic gases, and cements. Plastic model glue and nail polish removers are still used extensively. Substances most likely chosen by inhalant abusers have these characteristics in common:

(1) Substances exist in consumer products which are readily available to the public (can be purchased in grocery stores, drug stores, paint stores, etc.).

(2) Substances can be inhaled easily into the respiratory tract.

(3) Substance selected acts either as a stimulant or a depressant on the user's central nervous system.

(4) Substance the user is inhaling can prove fatal.

b. **Signs/Symptoms of Inhalant Abuse.** Included are the following:

(1) Disorientation.

(2) Tachycardia.

(3) Loss of reflexes.

(4) Unconsciousness.

(5) Respiratory and/or cardiac failure.

NOTE: Inhalant users describe the sensations they feel from inhalants as euphoric (an excessive feeling of happiness and well-being) and exciting along with the feeling that something wonderful is about to happen. Unfortunately, these feelings are often accompanied by a sense of reckless abandon and sense of being all powerful, feelings which often lead to impulsive and/or destructive acts.

c. **Treatment for Inhalant Abuse.** Follow this procedure:

(1) Support the patient's vital signs.

(2) Administer oxygen to the patient.

4-9. COMMON SYMPTOMS OF DRUG ABUSE

In the beginning stages, not all the changes a user experiences appear to be bad. For example, someone who is usually bored and sleepy may become more alert while using amphetamines. As a result, his job or school performance may improve. A person who is nervous and high- strung may become more cooperative and easier to manage when he takes barbiturates. It is, therefore, necessary to look for more than just negative changes in a person's character. Behavior that is out of the ordinary for an individual and that continues over a period of time may indicate drug abuse.

a. **General Indications.** Signs which may suggest drug abuse include sudden and dramatic changes in discipline and job performance. Drug abusers may also display unusual degrees of activity or inactivity. They may for no reason become very emotional; for example, very angry. Significant changes for the worse in personal appearance may be cause for concern. Often a drug abuser will not care about his personal appearance and health habits.

b. **Specific Indications.** There are other more specific signs which should arouse suspicion, especially if one or more are exhibited by a single person. Among these signs are furtive behavior regarding actions and possessions (fear of discovery), sunglasses worn at inappropriate times and places (to hide dilated or constricted pupils), and long-sleeve garments worn constantly, even on hot days (to hide needle marks).

c. **Indications of Severe Drug Abuse.** Because of the expense of supporting a drug habit, the abuser may try to borrow money from a number of individuals. If this fails, he will not be reluctant to steal items which can be converted to cash easily such as cameras, radios, and jewelry. If his habit is so severe that he must use drugs while on duty, he may be found in places such as closets or storage rooms at odd times.

4-10. CLOSING

Drug abuse is a widespread problem in our society, a problem which occurs in equally high frequency in the military. While the military's official policy does not tolerate drug abuse, some people continue to violate that policy or begin to abuse drugs while on active duty. Some of these active duty members use drugs to treat underlying mental illness, others to escape, or because they have yielded to peer pressure. In your role as a medical NCO, you will encounter people who abuse drugs. You can help by learning about the effects of drugs. Additionally, become knowledgeable at each duty station about referral sources available to a person who needs treatment.

Continue with Exercises

EXERCISES, LESSON 4

INSTRUCTIONS. The following exercises are to be answered by completing the incomplete statement or by writing the answer in the space provided. After you have completed all the exercises, turn to the solutions located at the end of the exercises and check your answers.

1. Drug abuse may be defined as the excessive taking of a drug that produces effects on a person's _____, thoughts, and _____; drugs taken without the advice or direction of a _____ and not for treatment of a disease or _____; a drug whose effects could lead to _____ behavior.

2. A person has become psychologically dependent on a drug when _____ _____ _____.

3. Physical dependence on a drug exists when an individual's body has _____ _____ _____.

4. Tolerance to a drug refers to the fact that _____ _____.

5. The term opioid refers to any drug which has _____ actions.

6. List three examples of drugs in the opioid class.

   a. _____.

   b. _____.

   c. _____.

7. List three signs/symptoms of intoxication/overdose of opioids.

   a. _____.

   b. _____.

   c. _____.

8. List three signs/symptoms of withdrawal from opioids.

   a. _____.

   b. _____.

   c. _____.

9. Treatment for opioid abuse includes maintaining the _____; administering _____; and monitoring the patient's _____ _____.

10. Alcohol, barbiturates, and sedatives are grouped together as CNS depressant drugs because _____ _____.

11. List three signs/symptoms of withdrawal systems from central nervous system depressants.

    a. _____.

    b. _____.

    c. _____.

12. Two very common central nervous system stimulants are coffee and

    _____.

13. Three signs/symptoms of withdrawal from central nervous system stimulants are:

    a. _____.

    b. _____.

    c. _____.

14. The best known drugs in the cannabinoid class (drugs made from the hemp plant Cannabis sativa) are _____ and _____.

15. An individual who takes large doses of psilocybin, mescaline or peyote may experience a variety of effects that users call _____.

16. Write four signs/symptoms of psychedelic drug abuse.

    a. _____.

    b. _____.

    c. _____.

    d. _____.

17. List three signs/symptoms of phencyclidine abuse.

    a. _____.

    b. _____.

    c. _____.

18. List three procedures used to treat phencyclidine drug abusers.

    a. _____.

    b. _____.

    c. _____.

19. Signs and symptoms of inhalant abuse include:

    a. _____.

    b. _____.

    c. _____.

20. To treat a patient for inhalant abuse, follow this procedure:

    a. _____.

    b. _____.

21. Inhalants such as paint thinners and plastic model glue affect the user rapidly because _____

    _____

    _____.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 4

1. Moods.
   Feelings.
   Doctor.
   Health problem.
   Antisocial. (para 4-1b)

2. The drug is so central to a person's thoughts, emotions, and activities that he needs to continue using amounts of the drug to satisfy a craving or compulsion.
   (para 4-1d(1))

3. Has adapted so thoroughly to the presence of the drug that the user experiences withdrawal signs and symptoms if he stops using the drug suddenly.
   (para 4-1d(2))

4. As a person uses some drugs, he must increase the amount of the drug to achieve the effects he wants and that he felt the first time he used the drug.
   (para 4-1d(3))

5. Morphine-like. (para 4-2a)

6. You are correct if you listed any three of the following:

   Opium.
   Heroin.
   Morphine.
   Methadone.
   Meperidine (Demerol®). (para 4-2a)

7. You are correct if you listed any three of the following:

   Decreased urine output.
   Pinpoint, nonreactive pupils.
   Constipation.
   Sex hormone levels depressed.
   Wheals or hives at the injection site.
   Generalized itching.
   Decreased blood pressure.
   Suppression of the cough reflex.
   Drowsiness.
   Respiratory depression.
   Coma.
   Subnormal temperature.
   Hypoventilation.
   (para 4-2d(1))

8. You are correct if you listed any three of the following:

   Excessive secretion of tears.
   Profuse, watery nasal discharge.
   Sweating.
   Nausea and vomiting.
   Elevated pulse and blood pressure.
   Intestinal spasms.
   Diarrhea.
   "Goose flesh."
   Hyperventilation.
   pH imbalances. (para 4-2d(2))

9. Airway.
   Oxygen.
   Cardiac rhythm. (para 4-2)

10. These drugs all cause a generalized depression of the central nervous system. (para 4-3a)

11. You are correct if you listed any three of the following:

    Anxiety or weakness.
    Abdominal cramps.
    Nausea or vomiting.
    Orthostatic hypotension
    Visual hallucinations.
    Seizures.
    Delirium.
    Hyperthermia.
    Cardiovascular collapse. (para 4-3e(2)

12. Nicotine. (para 4-4a)

13. You are correct if you listed any three of the following:

    Apathy.
    Psychomotor depression.
    Sleep disturbances.
    Suicidal tendencies. (para 4-4b(2))

14. Marijuana.
    Hashish. (para 4-5a)

15. The psychedelic experience. (para 4-6a)

16. Dilated pupils.
Hallucinations (usually visual).
Unusual body sensations.
Panic. (para 4-6b(1))

17. You are correct if you listed any three of the following:

Sweating.
Catatonic muscular rigidity.
Amnesia.
Tachycardia.
Hypertension.
Hypersalivation.
Fever.
Convulsions.
Coma. (para 4-7b)

18. You are correct if you listed any three of the following:

Protect the patient.
Support the patient's vital signs.
Acidify the patient's urine.
Use suction to remove the excess saliva in the patient's mouth.
Administer Valium® for convulsions.
Schedule a psychiatric follow-up. (para 4-7c)

19. You are correct if you listed any three of the following:

Disorientation.
Tachycardia.
Loss of reflexes.
Unconsciousness.
Respiratory failure.
Cardiac failure. (para 4-8b)

20. Support the patient's vital signs.
Administer oxygen to the patient. (para 4-8c(1) and (2))

21. The gas from such substances is inhaled into the lungs which have a very large surface area. The inhaled gas passes through the lung surface into the bloodstream quite easily causing the user to feel the effects of the inhaled substance very quickly. (para 4-8a)

End of Lesson 4

LESSON ASSIGNMENT

LESSON 5	Combat Stress Reactions.
LESSON ASSIGNMENT	Paragraphs 5-1 through 5-10.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

5-1. Identify the major causes of combat stress reactions.

5-2. Identify normal reactions to the stress of combat.

5-3. Identify the more severe reactions to the stress of combat.

5-4. Identify the appropriate treatment methods for combat stress reactions.

5-5. Identify the role of the medical NCO in the prevention and treatment of combat stress reactions.

SUGGESTION After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 5

COMBAT STRESS REACTIONS

5-1. INTRODUCTION

In combat, soldiers experience overwhelming stress reactions which may result from physical exhaustion, constant alertness, the trauma of seeing fellow soldiers wounded or killed, the fear of being killed or maimed, and the fear of killing other persons. Generally, combat stress reactions are temporary and do not require a soldier to be removed from combat conditions. If, however, a soldier cannot function effectively in his job and his safety, as well as the safety of others, is compromised, he must be evacuated.

a. **Nature of Combat.** Combat is intentionally the most stressful activity in which human beings engage. The enemy is deliberately trying to break our will and our mental ability to fight back. We are deliberately trying to break the enemy's will and must, at times, intentionally accept intense stress to catch the enemy by surprise or hit him when he least expects. In combat, we must be prepared to outlast the enemy in a test of mental endurance.

b. **Ancient Battlefields.** Actually, the battlefields of antiquity were far more "lethal" than those of recent history. It was not uncommon for the ancient Persians, Greeks, and Romans to see 40,000 to 80,000 soldiers hacked to death within a square mile during an afternoon. Activity on the battlefield was fierce. Soldiers fought shoulder-to-shoulder with their comrades, fought to the sound of drums and trumpets, fought beneath waving flags and standards. These fighters were pitting their strength, courage, and endurance against those of their enemies. When one side "lost heart," became demoralized, and turned and ran, they were massacred.

c. **Change of Tactics.** Gunpowder, which did not depend on courage, strength, or endurance, changed the nature of battle. When finally packaged in long-range rifles and exploding shells, gunpowder made it too dangerous to stand shoulder-to-shoulder with comrades. Tactics changed, and fighters on the battlefield became very scattered. Soldiers today rarely see more than a glimpse of the enemy or his machines. Today's soldier sees only a few members of his own small team.

d. **Change in Nature of Battlefield Death.** The change in the nature of battle changed the nature of battlefield death. Today death can strike without warning, not just for an afternoon but at any instant over days, weeks, or months. Actually, fewer soldiers are killed in battle out of the total numbers involved because soldiers are more spread out. The nature of stress has intensified, however, because of the impersonal, prolonged, random nature of the threat.

5-2. DEFINITION OF COMBAT STRESS/COMBAT STRESS REACTIONS

a. **Combat Stress.** Combat stress is the stress (internal responses caused by external forces) experienced by an individual in combat. Causes of such stress include fear of death, fear of failure, other intense, painful emotions such as grief and guilt, uncertainty, boredom, worries about what is happening back home, and the many physical and mental demands of combat duties.

b. **Combat Stress Reactions.** Combat stress reactions refer to the individual's responses to the stresses he experiences in combat. Like other stress reactions, these can be either positive (contributing to the success of the mission and the survival of the individual soldier), partly positive (contributing to either the success of the mission or to survival, but not to both), or negative (contributing to failure of the mission and the death of the individual). The term "combat stress reactions" is a general term that covers a wide range of behaviors from highly positive to totally negative.

c. **Range of Combat Stress Reactions.** There are a wide range of combat stress reactions. Because there are so many causes of stress in combat, soldiers generally stay near the middle of the range most of the time. Soldiers are confident but afraid and angry, strong and alert yet feeling butterflies in their stomachs. But if soldiers believe that the enemy strength is too great, that their leaders, buddies, and supporting units are unreliable, that their nerve is failing, their stress begins to feed upon itself until these soldiers become ineffective.

d. **Battle Fatigue and Combat Stress Reactions.** Battle fatigue is a deliberately nondescript term for a wide variety of behavioral, mental, and physical symptoms which are possible in any soldier in a combat environment. The causes of battle fatigue are the many stresses of combat. Combat stress reactions such as hyperalertness, fear, anxiety, carelessness, loss of confidence, depression, and total exhaustion can be part of battle fatigue. On the other hand, "improper behavior" combat stress reactions are not called battle fatigue. "Improper behaviors" include malingerers (those who deliberately fake illness or injury to escape from duty) and those who inflict wounds on themselves. Such behaviors are not classified as battle fatigue.

5-3. CAUSES OF COMBAT STRESS REACTIONS

Specific causes of combat stress reactions include the following:

a. Fear.

b. Intensity of battle.

c. Fatigue.

d. Tactical situation.

e. Lack of group/unit cohesiveness.

f. Friends killed in action or missing in action.

g. Leadership failures.

h. First combat experience.

i. Soldier's feeling that his luck is running out.

j. Anxiety or indecision in combat.

5-4. NORMAL REACTIONS TO THE STRESS OF COMBAT

a. **General Information.** Every soldier in combat is affected by stress to some degree. Normally, a soldier will experience fear, tension, tremors, etc. At times, he will find it hard to think or communicate clearly. He will feel grief for lost comrades. He may feel badly about what he has done or not done well enough. These reactions are so "common" that each soldier should be prepared to expect them. They are the "normal" responses to the danger and horror of combat. If a soldier shows none of the "normal" responses to combat, he may have reached a stage of fatalism, uncaring, or apathy--a very serious state of being.

b. **Normal Physical Reactions to the Stress of Combat.** Included are the following:

(1) Tension: aches, pains, trembling, fidgeting, fumbling things.

(2) Jumpiness: starting at sudden sounds or movements.

(3) Cold sweat: dry mouth, pale skin, eyes hard to focus.

(4) Pounding heart: may feel dizzy or light-headed.

(5) Breathlessness: feeling out of breath; may breathe too much until fingers and toes start to tingle, cramp, and go numb.

(6) Upset stomach, may throw up.

(7) Diarrhea, constipation, or frequent urination.

(8) Emptying bowels and bladder at instant of danger.

(9) Fatigue: feeling tired, drained; takes an effort to move.

(10) Distant, haunted, "1000 yard" stare.

c. **Normal Mental and Emotional Reactions to the Stress of Combat.** Included are the following:

(1) Anxiety: keyed up, worrying, expecting the worst.

(2) Irritability: swearing, complaining, easily bothered.

(3) Difficulty paying attention, remembering details.

(4) Difficulty thinking, speaking, communicating.

(5) Trouble sleeping; awakened by bad dreams.

(6) Grief: tearful, crying for dead or wounded buddies.

(7) Feeling badly about mistakes or what had to be done.

(8) Anger: feeling let down by leaders or others in the unit.

(9) Beginning to lose confidence in self and the unit.

5-5. SEVERE REACTIONS TO THE STRESS OF COMBAT

a. **General Information.** Severe reactions may be defined as reactions which cause the soldier to be unable to function on the job, compromise the safety of other soldiers, and/or compromise his own safety. These reactions create an emergency in the situation in which the reactions occur. These reactions may endanger either the mission, the soldier, or other soldiers.

b. **Severe Physical Reactions to the Stress of Combat.** Included are the following:

(1) Disabling fatigue: slowed down, just stands or sits.

(2) Catatonic freezing: may appear dazed or paralyzed; cannot function on the job or follow orders.

(3) Shaking (of arms or whole body); cowering in terror.

(4) Part of body won't work correctly with no physical reason: can't use hand, arm, or legs; can't see, hear, or feel, partially or at all.

(5) Vacant stare, "spaced out"; staggers and sways when he stands.

c. **Severe Mental and Emotional Reactions to the Stress of Combat.** Included are the following:

(1) Incoherent language: severe stuttering, mumbling, can't speak at all.

(2) Panic running under fire.

(3) Memory loss--for orders, military skills, and a bad event; for time, place, and what's going on; or for everything.

(4) Severe anxiety: afraid to fall asleep for fear of terrifying dreams, danger; unable to stay asleep even in a safe area.

(5) Disabling depression.

(6) Apathy: no interest in food or anything else.

(7) Hysterical outbursts, frantic or strange behavior.

(8) Seeing or hearing things which are not really there.

5-6. DIAGNOSIS OF THE REACTIONS TO THE STRESS OF COMBAT

a. **General Information.** There is no easy way for the medical NCO to recognize combat stress reactions and their severity quickly. That requires judgment based on what the leader, the unit medic, or the medical professional knows about the individual soldier, what has happened to the soldier, how the soldier responds to helping actions, what is likely to happen to the unit next, and what resources are available to the unit. Observations of changes in the soldier's behavior are very important for early diagnosis of problems. The medical NCO may have to rely on information from the soldier's buddies as well as the unit leader.

b. **Other Illnesses with Similar Signs/Symptoms.** It is often difficult to differentiate between combat stress reactions and true physical or mental illnesses which have very similar signs and/or symptoms. Examples of illnesses which could be mistaken for combat stress reactions include:

(1) Alcohol abuse: intoxication or withdrawal.

(2) Drug abuse: overdose or withdrawal.

(3) Atropine psychosis.

(4) Gas poisoning.

(5) Early heat stroke.

(6) Hypothermia.

(7) True laser blindness.

(8) Schizophrenia.

(9) Mania.

(10) Personality disorders.

5-7. METHODS OF TREATING SEVERE REACTIONS TO THE STRESS OF COMBAT

a. **Basic Treatment Principles.** The basic treatment principles are:

(1) Proximity.

(2) Immediacy.

(3) Expectancy.

NOTE: The expression "Easy as PIE" is a useful memory aid.

b. **Proximity/Immediacy/Expectancy.** In order to treat soldiers experiencing combat stress reactions effectively, treatment must take place as close to the unit as possible--treatment in the "proximity" of combat. It is best to treat them within their own units if their condition and the tactical situation permit. It has been consistently found that the further a soldier is removed from his unit, the less likely he is to return to full duty. The soldier should be treated as soon as possible--"immediacy." The longer the reactions last, the harder it is for the soldier to give them up. Finally, the soldier is treated with the clear expectation that he will recover fully after rest and replenishment (food and liquids)--"expectancy."

c. **Rest/Sleep.** Treatment consists of rest, replenishment (sleep, food, water, hygiene), reassurance, and activities to restore confidence. The soldier should have a minimum of four hours sleep, six to eight hours would be better. If necessary, he could sleep two three-hour periods with light work in between. The soldier should be told at the beginning that this treatment will be short and simple. He should be reassured that this is not a weakness but quite normal, a condition experienced by others. Give the soldier a chance to talk about how he feels. Listen attentively without interrupting, do not argue, and emphasize to him his natural coping skills.

d. **Treat in Unit.** Given rest and replenishment treatment in the unit, soldiers with severe reactions to the stress of combat are often able to return to full duty in a matter of days. Mild cases can be treated in this manner in their immediate units or in the combat service support units of the next higher headquarters located in a more stable rear area, treated without being under the direct care of medical personnel. It is generally preferable to rest the soldier with his comrades rather than evacuate him to a medical unit. The common physical complaints can be attended to during routine sick call. Medical personnel must, however, exercise supervision over such rest areas to assure that soldiers with serious illnesses are not being overlooked.

e. **Military Environment.** Treat the soldier in a military not a hospital environment. Keep the soldier in uniform not in pajamas. Maintain rank distinctions and military courtesy. Assign the soldier to do tasks between periods of rest, if possible.

f. **Medication.** Medicate the soldier only as a last resort. Sedatives such as Valium® can be given. Only sedate him if he is disruptive and requires evacuation.

g. **Return to duty.** Return the soldier to duty as soon as possible. Past experience indicates that failure to return the soldier to duty leads to a permanent disability for him.

h. **Evacuation.** Evacuate the soldier only if absolutely necessary. Soldiers with disruptive (severe) reactions to the stress of combat may require evacuation. As the medical NCO, you recommend to the commanding officer or his representative that the soldier be evacuated. When evacuating the soldier, use physical restraints only if necessary to control the soldier or to comply with regulations.

5-8. PROGNOSIS FOR SUCCESSFUL RETURN TO DUTY

a. **Soldier's Performance After Treatment.** Soldiers who have been treated for severe reactions to the stress of combat are least likely to relapse if they return or are still in their original units and are accepted there by their old comrades. A rough "rule of thumb" is: "<u>After treatment for strong reactions to the stress of combat, a good soldier will be good again</u>. <u>A new soldier deserves a second chance</u>. <u>A poor soldier may need reclassification and reassignment.</u>" Experience indicates that 70 percent of soldiers so treated will return to full duty within the first two days. Another 20 percent will return to full duty within 96 hours.

b. **Soldier's Possibility of Relapse After Treatment.** Good soldiers who are temporarily overloaded by the combination of stressors in combat will be no more likely to overload again than other good soldiers in the same situation. These soldiers need to be welcomed back, treated appropriately, and given jobs of increasing responsibility. They will be less likely to break than an unknown new replacement. If sent to a strange unit, they will be at some increased risk, temporarily, as are all new replacements.

5-9. ROLE OF THE MEDICAL NCO IN PREVENTION/TREATMENT OF SEVERE COMBAT STRESS REACTIONS

a. Severe combat stress reactions are the result of emotional or mental overwork. There are two common themes which interact in varying combinations in most soldiers experiencing severe reactions to the stress of combat--loss of confidence and internal conflict of motives.

b. Severe combat stress reactions are not cowardice or simple lack of motivation. The coward feels no internal conflict and will malinger, shirk, or go AWOL without shame, with only anxiety over getting caught. The soldier having severe combat stress reactions, in contrast, wants to do his duty, but has reached the stage of stress where he doubts that he can and may temporarily be unable to do so.

c. Physical fatigue, sleep loss, dehydration, and other low-grade physical illnesses do not need to be involved in severe combat stress reactions, but these factors are often present. When these factors are present, they decrease the soldier's ability to perform mental or physical tasks and skills and, therefore, decrease the soldiers' confidence in their ability to prevail under stress. It is possible to restore the soldiers' physical state and still have them incapacitated by crippling loss of confidence.

d. Recognizing how these common themes of loss of confidence and internal conflict of motives apply to each soldier suffering from severe reactions to the stress of combat can help the medical NCO restore soldiers to effectiveness. Leaders' and treaters' actions must raise the soldiers' confidence and help resolve internal conflict in favor of a sense of duty.

e. Specific actions by the medical NCO include:

(1) Identifying soldiers who might be exhibiting severe reactions to the stress of combat.

(2) Providing appropriate treatment.

(3) Referring the soldier for evacuation.

(4) Training personnel (and self) in preventive methods.

f. What the individual can do to alleviate combat stress:

(1) Rest and sleep as often as possible.

(2) Learn to relax.

(3) Ventilate (talk out troubles/problems).

(4) Develop readiness/preparation plans.

g. What peers can do to alleviate combat stress:

(1) Recognize symptoms in one another and report to the appropriate person.

(2) Provide peer feedback.

(3) Serve as a sounding board for others in the unit who want to talk out their reactions.

(4) Practice crisis management techniques with a buddy displaying combat stress reactions.

h. What leaders can do to manage stress in the unit:

(1) Promote unit cohesion. A basic motivator in keeping soldiers doing their duty in combat is unit cohesion. Unit cohesion is the personal trust and loyalty among members of a small unit, a unity which makes the soldiers want to stick together even when that involves great hardship and danger. The soldiers must work together to overcome danger and survive. The leader needs to encourage as much personal cohesion as possible within the team before soldiers go into combat.

(2) Take care of the troops. The leader must look out for the welfare of the troops. He must ensure the best water, food, equipment, shelter, sanitation, and sleep possible under the circumstances of the mission. In combat, never waste the strength of the soldiers for nothing because there will be many occasions when it will be necessary to accept hardship to gain the advantage. When that happens, explain to the troops why the hardship is necessary.

(3) Keep information flowing. Keep the troops well-informed of their goals, the situation, and how they are doing. Do not conceal unpleasant possibilities, but put dangers in the perspective of how the team will overcome them.

(4) Practice sleep logistics. Be sure the soldiers practice sleep logistics, a flexible plan by which everyone gets enough sleep. In the combat setting and in training for it, never miss a chance to give somebody in the unit safe sleep.

(5) Maintain unit readiness. Conduct tough, realistic training. Soldiers' ability to withstand stress is increased by a realistic sense of confidence. Confidence in each soldier's own ability, in his leadership, and in his equipment is extremely important. This confidence is obtained initially through tough, realistic training and, later, through success on the battlefield.

(6) Maintain control of the unit. The leader must always be in control.

(7) Initiate a stress coping program. Instruct soldiers about how to relieve their own stress (paragraph 5-9f) and how to help their buddies (paragraph 5-9g).

5-10. CLOSING

Reactions to the stress of combat are inevitable, but severe reactions can be reduced. History shows that highly trained and cohesive units have less than one combat stress related casualty for every ten wounded in action, even in very heavy fighting. This is significantly less than the usual one per four or five. By knowing what factors in the tactical and overall situation increase severe combat stress reactions, the medical NCO as well as leaders, buddies, and the individual soldier can take action to share the burden, resolve the internal conflict of motives, and reduce the stress. By thorough, realistic training which builds confidence and by caring for each other in combat, soldiers can deal with the stresses of current warfare.

Continue with Exercises

EXERCISES, LESSON 5

INSTRUCTIONS. The following exercises are to be answered by completing the incomplete statement or by writing the answer in the space provided. After you have completed all the exercises, turn to the solutions located at the end of the exercises and check your answers.

1. Combat stress reactions refers to _____

   _____.

2. If soldiers believe that the enemy strength is too great, that their leaders are unreliable, and that their (the soldiers') nerve is failing, the soldiers' stress begins to _____, and the soldiers become ineffective.

3. List five causes of combat stress reactions.

   a. _____.

   b. _____.

   c. _____.

   d. _____.

   e. _____.

4. List three normal physical reactions to the stress of combat.

   a. _____.

   b. _____.

   c. _____.

5. List five normal mental/emotional reactions to the stress of combat.

   a. _____.

   b. _____.

   c. _____.

   d. _____.

   e. _____.

6. Disabling fatigue, catatonic freezing, and cowering in terror are all examples of _____ _____ _____ to the stress of combat.

7. Seeing or hearing things which are not really there, disabling depression, incoherent language, and lack of interest in food or anything else are signs/symptoms of _____ _____ / _____ reactions to the stress of combat.

8. List three illnesses which could be mistaken for combat stress reactions.

   a. _____.

   b. _____.

   c. _____.

9. Remember the word PIE which stands for the basic treatment principles for combat stress reactions: _____, _____, and _____.

10. Three steps an individual soldier can do to relieve combat stress are:

    a. _____.

    b. _____.

    c. _____.

11. List four actions a medical NCO can take to treat/prevent combat stress in the unit.

    a. _____.

    b. _____.

    c. _____.

    d. _____.

12. A leader can manage stress in the unit by promoting _____, soldiers doing their duty in combat.

13. Tough realistic training helps a soldier to withstand stress because such training builds _____.

14. Inform troops about even unpleasant situations. In such situations, stress _____.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 5

1. An individual's responses to the stresses he experiences in combat. (para 5-2b)

2. Feed upon itself. (para 5-2c)

3. You are correct if you listed any five of the following:

   Fear.
   Intensity of battle.
   Fatigue.
   Tactical situation.
   Lack of group/unit cohesiveness.
   Anxiety/indecision in combat.
   Friends killed/missing in action.
   Leadership failures.
   First combat experience.
   Feeling that luck running out. (para 5-3)

4. You are correct if you listed any three of the following:

   Tension.
   Jumpiness.
   Cold sweat.
   Fatigue.
   Pounding heart.
   Breathlessness.
   Distant, haunted stare.
   Upset stomach.
   Diarrhea, constipation, frequent urination.
   Danger and emptying bowels/bladder. (para 5-4b)

5. You are correct if you listed any five of the following:

   Anxiety.
   Irritability.
   Difficulty paying attention.
   Difficulty thinking, speaking, communicating.
   Trouble sleeping, bad dreams.
   Grief.
   Feeling badly about mistakes.
   Anger.
   Loss of confidence in self and unit. (para 5-4c)

6. Severe physical reactions. (para 5-5b)

7. Severe mental/emotional reactions. (para 5-5c)

8. You are correct if you listed any three of the following:

   Alcohol abuse.
   Hypothermia.
   Drug abuse.
   True laser blindness.
   Atropine psychosis.
   Schizophrenia.
   Gas poisoning.
   Mania.
   Early heat stroke.
   Personality disorders. (para 5-6b)

9. Proximity.
   Immediacy.
   Expectancy. (para 5-7a)

10. You are correct if you listed any three of the following:

    Rest and sleep as often as possible.
    Learn to relax.
    Ventilate.
    Develop readiness/preparation plans. (para 5-9f)

11. a. Identify soldiers who might be showing severe reactions to the stress of combat.
    b. Provide appropriate treatment.
    c. Refer the soldier for evacuation, if necessary.
    d. Train other personnel in preventive methods. (para 5-9e)

12. Unit cohesion. (para 5-9h(1))

13. Confidence. (para 5-9h(5))

14. How troops will overcome any unpleasant possibilities. (para 5-9h(3).)

End of Lesson 5

LESSON ASSIGNMENT

LESSON 6	Death and Dying.
LESSON ASSIGNMENT	Paragraphs 6-1 through 6-4.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

6-1. Identify the typical reactions of health care personnel toward the terminally ill or injured patient.

6-2. Identify the stages of adjustment experienced by the terminally ill or injured patient and his significant others.

6-3. Identify the characteristics of each stage of adjustment experienced by the terminally ill patient and his significant others.

6-4. Identify the management techniques used to help the terminally ill and their significant others cope with death and dying.

6-5. Identify the methods used by the medical NCO in helping soldiers cope with death and dying in a combat environment.

SUGGESTION After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 6

DEATH AND DYING

6-1. INTRODUCTION

Just as being born is a natural process, dying is also a natural process. Death is inevitable no matter how we may want to prolong life. Many people avoid the discussion of death because it is so anxiety-provoking a subject. The subject reminds us of our human weaknesses despite all technological advances. Death is the last human experience, a fact which makes it difficult to help those who are terminally ill. As a medical specialist, you will be faced frequently with the reality of another person's death. This experience can be very painful and stressful. It is only natural for fears of death and personal concerns to intensify whenever you are in contact with someone who is dying.

6-2. REACTIONS OF HEALTH CARE PERSONNEL TOWARD TERMINALLY ILL OR INJURED PATIENTS

To work effectively with a dying patient, you must recognize and understand the individual's needs, feelings, tension, and discomfort. Coming to terms with yourself will be your greatest asset.

a. **Denial.** Some personnel may tend to deny the reality of death or try to avoid patients who are terminally ill. Death is seen as a failure because it cannot be prevented. Some personnel may even "tune out" or "tune off" terminally ill patients by maintaining an objective, professional approach.

b. **Common Inappropriate Actions/Responses to Terminally Ill Patients Who Wish to Talk about Death.** The medical specialist should avoid the following expressions:

(1) Reassurance. "Everything will be all right."

(2) Denial. "You're not going to die."

(3) Fatalism. "We all have to die sometime."

(4) Changing the subject. "Let's think of something else to talk about."

c. **Appropriate Actions/Responses to Terminally Ill Patients.**

(1) Gentle discussion. Be aware of how you talk to the patient.

(2) Exploration of feelings. Allow the patient the time and opportunity to ventilate his feelings.

(3) Active listening. Be attentive when the patient talks.

6-3. PSYCHOLOGICAL RESPONSES TO THE DYING PROCESS

Research has been done by interviewing terminally ill patients and their families to gain information about psychological responses to the dying process. The conclusions of the research are that there are five basic stages of dying: denial, anger, bargaining, depression, and acceptance. A patient may or may not follow these stages in a fixed pattern. He may stop, regress, or not even progress beyond the first stage. If family members are present, they will usually pass through the same stages as the patient, not necessarily at the same time.

a. **Denial.**

(1) Patient reactions. The patient may:

(a) Seek opinions of other physicians.

(b) Request repeat of certain tests.

(c) State that the test results belong to someone else.

NOTE: These actions are usually characterized by "No, Not me!" "It can't be true!" or "There must be some mistake!"

(2) Health care provided by the medical specialist.

(a) Listen. Do not contradict the patient.

(b) Reinforce prescribed medication/diet routine as prescribed by the physician.

(c) Respect the patient's wish to deny impending death.

b. **Anger.**

(1) Patient reactions. The patient may:

(a) Replace denial with questions, feelings of anger, rage, resentment, and envy.

(b) Blame, complain, find fault, and be extremely critical of the care he is receiving.

NOTE: These actions may be characterized by "Why me?" "Why should this be happening to me?" or "What have I ever done to deserve this punishment?"

(2) Health care provided by the medical specialist.

(a) Have patience and tolerance.

(b) Acknowledge to the patient that you understand how he feels.

(c) Allow the patient to express anger and other feelings.

(d) Respect the patient's need to rage against his fate. Do not take the attack personally.

c. **Bargaining.**

(1) Patient reactions. This stage may be quite short, intermittent, or not even apparent. The patient may:

(a) Bargain to postpone death, seek reward for good behavior, or exchange places with someone else.

(b) Replace the previous question of "Why me?" to "yes, it is me, but if you will just let me live, I will never say an unkind word to anyone or never lose my temper, or etc."

NOTE: This stage may be done privately.

(2) Health care provided by the medical specialist.

(a) Understand that bargaining is helpful to the patient.

(b) Keep the patient comfortable.

(c) Listen and be available.

d. **Depression.**

(1) Patient reactions. The patient:

(a) May be anxious to put affairs in order.

(b) Sense a great loss (income, business, hair, limb, function, life).

(c) Have feelings of sadness and guilt over not having provided for his family, makes a will, or updates a will.

(2) Health care provided by the medical specialist.

(a) Allow the patient to mourn, cry, and talk about losses.

(b) If possible, help the patient take care of putting affairs in order.

(c) Provide emotional support.

e. **Acceptance.**

(1) Patient reactions. The patient:

(a) Is prepared to die.

(b) Is at peace.

(c) Is tired.

(d) May withdraw from all except a special loved one.

NOTE: The patient wants to be left alone or have someone sit near, but in silence. Family often needs more support than the patient. This is the time when it is too late for so many words. It is also the time when relatives cry hardest for help--with or without words.

(2) Health care provided by the medical specialist in a medical treatment facility.

(a) Respect the patient's need for quietness and offer reassurance by being there as much as possible.

(b) If the patient is unresponsive, do not discuss the patient in his room--hearing is the last sense to cease function.

(c) If the patient does not want to talk, communicate nonverbally to indicate a sense of caring and concern.

(d) Keep the patient as comfortable as possible.

(e) Maintain emotional support for the family.

NOTE: The medical specialist can be of great help during those final moments if he can understand the family's conflicts at this time and help select the one person who feels most comfortable staying with the patient. Those who feel too uncomfortable can return home knowing the patient will not die alone with no guilt for avoiding the moment of death.

6-4. COPING WITH DEATH AND DYING IN A COMBAT ENVIRONMENT

Health care provided by the medical specialist includes the following:

a. Make the casualty as comfortable as possible.

b. If possible, find someone who can sit with the soldier (hopefully, a buddy from his unit).

c. Offer to take care of unfinished business or notify his family, if possible.

NOTE: The buddy of the deceased, or whoever is with the casualty at the time of his death, can provide feedback to include when and where the soldier died.

d. Encourage the casualty to express feelings of grief.

e. If possible, make time for a brief service of some sort, however simple.

NOTE: The expression of grief by survivors is important to prevent post-combat psychological problems of those who saw their buddies killed in action. Many of the mental health professionals now treating Vietnam veterans with post-traumatic stress disorders feel that too often the soldiers didn't allow themselves to grieve for their buddies at the time (or soon after), and so their buddies' deaths still haunt the veterans today.

Continue with Exercises

EXERCISES, LESSON 6

INSTRUCTIONS. The following exercises are to be answered by completing the incomplete statement or by writing the answer in the space provided. After you have completed all the exercises, turn to the solutions located at the end of the exercises and check your answers.

1. List two common inappropriate responses by health care personnel to the terminally ill patient.

   a. _____.

   b. _____.

2. List the five stages of adjustment experienced by the terminally ill or injured.

   a. _____.

   b. _____.

   c. _____.

   d. _____.

   e. _____.

3. A terminally ill patient may not go through all the stages of adjustment or go through these stages in the exact sequence listed in this lesson.

   a. True.

   b. False.

4. The patient requesting repeat of some medical tests and the opinion of other physicians is typical of the _____ stage of adjustment.

5. The patient seeking a reward for good behavior is characteristic of the _____ stage of adjustment for the terminally ill patient.

6. The terminally-ill patient who is at peace and perhaps withdrawn is in the

   _____ stage of adjustment.

7. The patient feeling sad, guilty, and a sense of loss may be in the

   _____ stage of adjustment.

8. The terminally ill patient feeling rage, resentment, and a "Why me?" attitude is in

   the _____ stage of adjustment.

9. List three supportive measures the health care provider can take for the terminally-ill patient in the depression stage of adjustment.

   a. _____.

   b. _____.

   c. _____.

10. List three supportive measures the health care provider can take in a combat environment for the dying casualty.

    a. _____.

    b. _____.

    c. _____.

11. List two generally supportive responses the health care provider can give to the terminally-ill patient in a medical treatment facility.

    a. _____.

    b. _____.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 6

1. You are correct if you listed any two of the following:

   "Everything will be all right." -- reassurance.
   "You're not going to die." -- denial.
   "We all have to die sometime." -- fatalism.
   "Let's think of something else to talk about." --changing the subject.
   (para 6-2b)

2. a. Denial.
   b. Anger.
   c. Bargaining.
   d. Depression.
   e. Acceptance. (paras 6-3a through e)

3. a. A terminally ill patient may not progress through all the stages, perhaps not even beyond the first stage. Or, the patient may go through the stages, just not in the sequence listed in this lesson. (para 6-3)

4. Denial. (para 6-3a(1))

5. Bargaining. (para 6-3c(1))

6. Acceptance. (para 6-3e(1))

7. Depression. (para 6-3d(1))

8. Anger. (para 6-3b(1))

9. Allow the patient to mourn, cry, and talk about losses.
   Help the patient take care of putting his affairs in order, if possible.
   Provide emotional support. (para 6-3d(2))

10. You are correct if you listed any three of the following:

    Make the casualty as comfortable as possible.
    Find someone to sit with the soldier, if possible.
    Offer to take care of unfinished business or notify his family, if possible.
    Encourage the casualty to express feelings of grief.
    Make time for a brief service, if possible.
    (para 6-4)

11. You are correct if you listed any two of the following:

Quietly reassure the patient by being with him as much as possible.
Do not discuss the patient's condition in his room where he can hear what is said.
Indicate that you care and are concerned in a nonverbal manner to a patient who does not want to talk.
Keep the patient as comfortable as possible.
Maintain emotional support for the family.
(para 6-3e(2))

End of Lesson 6

LESSON ASSIGNMENT

LESSON 7	Sexual Assault.
LESSON ASSIGNMENT	Paragraphs 7-1 through 7-9.
LESSON OBJECTIVES	7-1. Identify the responsibilities and actions necessary by medical personnel when dealing with alleged sexual assault. 7-2. Identify evidence control procedures. 7-3. Identify recording principles.
SUGGESTION	After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 7

SEXUAL ASSAULT

7-1. INTRODUCTION

Sexual assault is rapidly becoming a prime concern of health care professionals. Sexual assault has no boundaries; anyone of any age, sex, race, social, or economic background may become a victim. These victims need to be cared for quickly, with dignity and compassion, while evidence must be handled with great care in accordance with the legal instructions provided by the authority involved.

7-2. DEFINITION OF SEXUAL ASSAULT

Rape is usually defined as the sexual attack upon a female by a male, but this is not necessarily the case. Another definition of rape is that it is an act of violence in which sexual relations are forced upon another person.

7-3. INITIAL CONTACT WITH RAPE VICTIM

In your first contact with the rape victim, advise the victim to avoid bathing, showering, or douching. Although the victim usually feels dirty and compelled to wash, the case must be reported to the emergency room (ER) immediately. The victim has rights and may choose not to accept your advice. Remember to keep in mind that the person you are dealing with is a victim and not a criminal.

7-4. EMERGENCY ROOM PERSONNEL DUTIES

Procedure for emergency room personnel is as follows:

a. Immediately notify the charge nurse.

b. Provide the patient with visual and auditory privacy.

c. Consult the emergency room Standing Operating Procedure (SOP). Local, state, or post law enforcement authorities may be involved. Each may have different requirements.

7-5. CHARGE NURSE RESPONSIBILITIES

The charge nurse performs these duties. (In that person's absence, these duties should be performed by the senior medical specialist.)

a. Notify the personnel concerned who are:

(1) The emergency medical resident on duty.

(2) The sexual assault crisis counselor.

(3) The pediatric chief resident (if the victim is single, under 18 years of age, and not on active duty).

(4) The military police (MP) for on-post assault or the local police for off-post assault.

(5) Other persons according to local SOP.

b. The charge nurse serves as victim advocate until the crisis counselor arrives. If the charge nurse is the opposite sex of the victim, the charge nurse may designate an individual of the same sex to act instead when direct victim contact is indicated.

c. The charge nurse provides for the victim's comfort, psychological support, and privacy.

d. The charge nurse obtains information about the victim's family or friends in order to notify these people.

e. The charge nurse briefs the victim on sexual assault medical and legal procedures.

f. The charge nurse arranges for an attendant of the same sex to stay with the victim throughout the examination.

7-6. EMERGENCY MEDICAL RESIDENT'S DUTIES

The emergency medical resident's duties include the following:

a. Examine the victim for serious injuries and provide treatment for initial resuscitation and stabilization.

b. Obtain written consent for the medical and legal examinations.

c. Obtain written consent for photographs, if necessary.

d. Perform medical and legal examination and collection of evidence.

e. Evaluate and treat all injures, prior to the victim leaving the emergency room.

f. Offer venereal disease and pregnancy prophylaxis (precautions taken to prevent disease/pregnancy) to the victim.

g. Notify gynecology (OB/GYN) for female victims. Notify urology for male victims, and notify pediatrics for children who are victims. These departments are notified for assistance when it is necessary and required for follow up.

7-7. RECORDING PRINCIPLES

a. **Evidence.** Evidence involving the suspect or suspects may also be collected. Documenting and recording of evidence should be accomplished carefully. Documentation and recording should follow these principles:

(1) Document each event carefully.

(2) Document only the pertinent medical data.

(3) Do not be involved except for gathering the medical information. (You are not the legal authority.)

(4) In your documentation, avoid using words such as rape, assault, attack, etc. Rape is a legal term and not a medical diagnosis. The medical team can only determine whether sexual intercourse has occurred and if injury was sustained.

b. **Records as Legal Documents.** Your records are legal documents; therefore, be sure to complete these records carefully. These records completed incorrectly could lead to difficulties with legal actions. If you use descriptive phrases, apply such words as alleged, and suspected instead of rape, attack, etc. When you include patient statements, state that fact, and quote the patient as accurately as possible.

7-8. EVIDENCE CONTROL PRINCIPLES

The sexual assault investigation kit is used to obtain evidence. The components of this kit are listed here:

a. **Forms.**

(1) Medical Examination Report (6 pages in triplicate).

(2) Notes to investigator.

(3) Notes to physician.

(4) Standard Form 558 (REV), Emergency Care Treatment.

(5) Standard Form 541, Medical Record GYN Cytology.

(6) DA Form 4137, Evidence/Property Custody Document (laboratory).

b. **Labels.** See table 7-1.

Quantity		Equipment for Specimen Collection
1 1	Investigator--pubic hair combing Investigator--head hair combing	2 - small plastic bags 1 - comb
2	Investigator sperm motility --yes/no (If sperm found, use fixative, give to investigator)	
2	Investigator acid phosphatase tube lab slip stamped acid phosphatase	2 - red, screw-top test tube tube with cotton-tip swab
2	Investigator cytology smears (stain for sperm) (ABO grouping)	
1	Lab Pap smear (fixative in GYN room)	1 - plastic container with glass slides
2	Investigator red-top blood tube lab slip HCG VDRL--circle one	2 - red-top test tubes
1	Investigator secretion status	1 - saliva collection paper 1 - plastic bag
2	Investigator fingernail scrapings --left/right	2 - small, screw-top tubes 1 - clippers 1 - wooden stick 1 - cotton-tip swab
1	Investigator or bag for clothing	1 - plastic bag 1 - patient's valuable checklist
1	HCG or UA lab slip	1 - plastic specimen cup
1	GC culture for N. gonorrhea	

Table 7-1. Supplies.

c. **Additional Equipment Added Prior to Examination.**

(1) One AGAR plate for GC culture--from refrigerator.

(2) Preservative for Pap smear--GYN room.

(3) Fourteen labels with patient identification information (to be attached to each specimen).

NOTE: There is a strictly controlled chain of custody in accordance with local statutes. DA Form 4137 is used for this purpose.

7-9. CLOSING

Sexual assault is a traumatic and emotional experience. It is easy to become caught up in these emotions and exceed your authority. This could actually slow down the legal process and/or subject you to legal action. The guidelines must be even more strictly followed when children are involved as the tendency to become protective of children often overshadows our common sense.

Continue with Exercises

EXERCISES, LESSON 7

INSTRUCTIONS. The following exercises are to be answered by completing the incomplete statement or by writing the answer in the space provided. After you have completed all the exercises, turn to the solutions located at the end of the exercises and check your answers.

1. One definition of rape is that it is an act of violence in which sexual relations are _____.

2. The first medical person who comes in contact with the rape victim should advise the person to avoid _____, _____, or _____.

3. The person in the emergency room responsible for notifying additional medical personnel is the _____.

4. The individual in the emergency room who acts as the victim's advocate until the crisis counselor arrives is the _____.

5. The _____ is responsible for obtaining written consent for medical and legal examination and photographs as well as offering venereal disease and pregnancy prophylaxis.

6. Document evidence obtained from the victim regarding the alleged sexual assault should be recorded on DA Form _____.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 7

1. Forced upon another person. (para 7-2)
2. Bathing, showering, or douching. (para 7-3)
3. Charge nurse. (para 7-5)
4. Charge nurse. (para 7-5b)
5. Emergency medical resident. (paras 7-6a through g)
6. 4137. (para 7-6)

End of Lesson 7